

5202

CERTIFICATE OF DEATH

Reg. Dist. No. 5103

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				c. LENGTH OF STAY IN 1b 40yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle William Last Abbott				4. DATE OF DEATH Month May Day 13 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1893		9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Newark, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Abbott				14. MOTHER'S MAIDEN NAME Nancy Burton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes War I		16. SOCIAL SECURITY NO. 705-07-9735		17. INFORMANT Address Mrs. Harry W. Abbott, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute left ventricular failure DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Coronary arteriosclerosis; myocardial fibrosis (c) 7 yrs.						INTERVAL BETWEEN ONSET AND DEATH sudden sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from November 41 , 19 41 , to May 13 , 19 60 , that I last saw the deceased alive on MAY April 20 , 19 60 , and that death occurred at 7:30 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Samuel M. Jacobson M.D.		ADDRESS (Street, city or town, state) 50 Pershing St.		DATE SIGNED 5/16/60			
PHYSICIAN'S NAME (Type) Dr. Samuel M. Jacobson, MD		Cumberland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAY 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-1



Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
Occupation		Education		Marital Status		Religion		Race	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and it should be signed by the physician or other qualified person who attended the deceased during his or her last illness. It should be filed with the Bureau of Vital Records as soon as possible after death.

2. The cause of death should be stated in as much detail as possible, and it should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness. It should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness.

3. The manner of death should be stated in as much detail as possible, and it should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness. It should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness.

4. The occupation, education, marital status, religion, and race of the deceased should be stated in as much detail as possible, and it should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness. It should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness.

5. The signature of the physician or other qualified person who attended the deceased during his or her last illness should be stated in as much detail as possible, and it should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness. It should be stated in the language of the physician or other qualified person who attended the deceased during his or her last illness.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5275

05194

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 E. MAIN ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSIE Middle M. Last AGNEW		4. DATE OF DEATH Month MAY Day 30 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 26, 1902
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT MERRBACH		14. MOTHER'S MAIDEN NAME JESSIE MATHEWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MAX AGNEW, 139 E. MAIN ST., FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 30, 1960 to May 30, 1960 , that (I) (we) last saw the deceased alive on May 28, 1960 , and that death occurred 9:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE WOMcLane		22b. DATE June 1, 1960	
22c. PHYSICIAN'S NAME (Type) WOMcLane MD		22d. ADDRESS Frostburg Md	
23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		23b. DATE THEREOF JUNE 1 '60	
23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Gunt		25a. REC'D BY REGISTRAR JUN 2 '60	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Charles J. K...	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5203
CERTIFICATE OF DEATH

05195
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/21/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Obie Middle Wilson Last Arnold		4. DATE OF DEATH Month May Day 6 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1872
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - LaVale Glass Worker		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luther Arnold		14. MOTHER'S MAIDEN NAME Matilda Queen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT P.O.Box 599	
Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Suicide Deterioration			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombo-angitis Obliterans			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/21/60 , 19____, to 5/6/60 , 19____, that I last saw the deceased alive on 3/6/60 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/7/60			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/9/60	
22c. NAME OF CEMETERY OR CREMATORY Davis		22d. LOCATION (City, town, or county) (State) W. Va. Davis	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
ADDRESS Davis, W. Va.		24b. REGISTRAR'S SIGNATURE C. L. Fries	

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CERTIFICATE OF DEATH

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Noted - Laval Glass Worker

Madison Green

Madison Green

Allegheny County Jail

Allegheny County Jail

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19 Green St.

Allegheny, Pa.

Dr. James M. Wilson

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386

CERTIFICATE OF DEATH

1936

1

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Name of physician: [illegible]

6. Name of informant: [illegible]

7. Signature of informant: [illegible]

8. Signature of physician: [illegible]

9. Signature of registrar: [illegible]

10. Date of registration: [illegible]

11. Name of registrar: [illegible]

12. Date of registration: [illegible]

13. Name of registrar: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5277

05197

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Savage</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Nott</u> Last <u>Barth</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22nd</u> , Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11th, 1879</u>		9. AGE (In years last birthday) <u>80 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.-Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C&P Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Barth</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bauer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. John Poland, Mt. Savage, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of the Stomach</u> DUE TO (c) <u>with local + regional metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <u>Uremia due to renal insufficiency and Coronary sclerosis</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 14, 1960</u> , to <u>May 22, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 21, 1960</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Alvin J. Walters</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Alvin J. Walters,</u>				22d. ADDRESS <u>48 Broadway, Frostburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-25-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. George's Ep. Cemetery, Mt. Savage,</u>		23d. LOCATION (City, town, or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Duurst</u>				ADDRESS <u>Frostburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 25 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>C. S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05198

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ohio</u> b. COUNTY <u>Cuyahoga</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambria</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Algonguin Hotel</u>				d. STREET ADDRESS <u>6041 Engle Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>L</u> Last <u>Beamer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 4, 1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BMI Recording Co West</u>		11. BIRTHPLACE (State or foreign country) <u>Budapest, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph C. Beamer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Duncan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Elma M. Nett New York</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 19 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bainhaver Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburg Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Camb. Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 23 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5278

CERTIFICATE OF DEATH

65199

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>5 Ds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lonaconing</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>Charlestown St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Sampson</u> Middle <u>Bittinger</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1882</u>			
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levi Bittinger</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Trout</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-18-2905</u>		17. INFORMANT <u>Joseph Bittinger-Manassas, Va.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9.22</u> 19 <u>58</u> to <u>5.14</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>5.14</u> 19 <u>60</u> , and that death occurred at <u>2</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. Miles, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5.16.60</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. MILES, JR., M.D.</u>				22d. ADDRESS <u>LONA CONING MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/17</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakhill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Lonaconing Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>El. Bral</u>				ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 18 '60</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

2858



James H. Smith



613-18-2700

James H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5205

CERTIFICATE OF DEATH

05200

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 26 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle LEROY Last BORST				4. DATE OF DEATH Month MAY Day 11 Year 19 60.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 17, 1902	
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Frt. Conductor				10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad			
11. BIRTHPLACE (State or foreign country) NEW YORK, Delhi				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JUDSON BORST				14. MOTHER'S MAIDEN NAME NANCY MC CUNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Carcinoma of Lung (2) DUE TO (b) — Conditions if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) — INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 — p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. City or town (County) (State) Cumberland City Md			
21. I certify that (I) (this hospital) attended the deceased from 3/7/58 19 — , to 5/11/60 19 — , that (I) (we) last saw the deceased alive on 5/10/60 , and that death occurred at 7:40 A.M. , the causes and on the date stated above.							
22a. SIGNATURE Dr. R. J. Williams				22b. DATE SIGNED 5/11/60			
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 13, 1960			
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR MAY 16 '60			
				25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			

1997

TABLE 1.1

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

VOLUME 1

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GENERAL HOSPITAL - CLEVELAND, OH.

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 MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5291 CERTIFICATE OF DEATH

15201

| | | | | | | | |
|---|----------------------------------|--|---------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RT. #1 FLINTSTONE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RT. #1 FLINTSTONE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle E. Last BROCKEY | | 4. DATE OF DEATH
Month MAY Day 29 Year 19 60 | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-12-1890 | 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Conductor | | 10b. KIND OF BUSINESS OR INDUSTRY
P. E. Street Cars | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHRISTOPHER F. BROCKEY | | | | 14. MOTHER'S MAIDEN NAME
MARGARET HUMBERTSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
PTS. CHART | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 arteriosclerotic heart disease DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week
1 year |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-24 19 60 , to 5-29 19 60 , that (I) (we) last saw the deceased alive on 5-28 19 60 , and that death occurred at 5-29 19 60 , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
L. Brings | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
DR. L. BRINGS | | 22d. ADDRESS
576 Green St. Cumberland Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 1, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Chaneyville Methodist | | 23d. LOCATION (City, town, or county) (State)
Chaneyville Pa. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, 230 Baltimore Ave. | | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1931

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IN THE STATE OF

IN THE COUNTY OF

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5289

05202

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Savage | | | | c. LENGTH OF STAY IN 1b
Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Carl Middle Edward Last Burkhart | | | | 4. DATE OF DEATH
Month May Day 28th , Year 19 60 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
May 18th, 1914 | 9. AGE (In years last birthday)
46 Yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shovel Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Mt. Savage Coal Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry Burkhardt | | | | 14. MOTHER'S MAIDEN NAME
Carrie Finzel | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
215-10-1272 | | 17. INFORMANT
Richard Burkhardt, Mt. Savage, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a), 420.1 <i>acute coronary thrombosis</i>
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) _____
DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1957 , to 5/28/60 , 19____, that (I) (we) last saw the deceased alive on April 19 1960 , and that death occurred at 3:04 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John A. Topper</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-31-60 | |
| 22c. PHYSICIAN'S NAME (Type)
John A. Topper | | | | 22d. ADDRESS
<i>Hyndman Pa.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-31-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Lutheran Cemetery, Accident, Md. | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>J. R. Durrant</i> | | | | ADDRESS
Frostburg, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 1 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur L. Huns</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

105711

STATEMENT OF DEATH

1952



First Name

Last Name

Address

City

State

Zip

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Previous Illnesses

Cause of Death

Place of Death

Date of Death

Time of Death

Signature of Doctor

Signature of Witness

Signature of Coroner

Signature of Burial Officer

Signature of Undertaker

Signature of Registrar

Signature of Health Officer

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Anthropologist

Signature of Archaeologist

Signature of Linguist

Signature of Historian

Signature of Geographer

Signature of Meteorologist

Signature of Astronomer

Signature of Botanist

Signature of Zoologist

Signature of Ecologist

Signature of Environmental Scientist

Signature of Public Health Officer

Signature of Epidemiologist

Signature of Biostatistician

Signature of Geneticist

Signature of Immunologist

Signature of Microbiologist

Signature of Virologist

Signature of Parasitologist

Signature of Entomologist

Signature of Mammalogist

Signature of Ornithologist

Signature of Paleontologist

Signature of Anthropologist

Signature of Archaeologist

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

45203

| | | | | | | | | | | | | | | | |
|--|--|----------------------------------|-----------------------------|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
 | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<input checked="" type="checkbox"/> Rural <u>Cumberland</u> | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | | | | | 1 d. STREET ADDRESS
<u>Route 5,</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>GEORGE</u> Middle <u>A.</u> Last <u>CAPEL</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1960</u> | | | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Sept. 15, 1941</u> | | 9. AGE (In years last birthday)
<u>18</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unemployed</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
 | | | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>George A. Capel, Sr.</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Elsie Dawson</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>220 38 0027</u> | | | | 17. INFORMANT Address
<u>Mr. George Capel, Route 5, Cumberland, Mdd.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u>
<u>816X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Skull Fracture</u>
(c) <u>40 Minutes</u>
DUE TO
(a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>40 Minutes</u>
<u>40 Minutes</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Automobile Accident MVE MV</u> | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>3:00</u> P. M. <u>May 8</u> 19 <u>60</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Rt. #220 Rt. #5 Cumberland, Allegany, Maryland</u> | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 8, 1960</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>May 11, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Frostburg Memorial Park</u> | | | | 22d. LOCATION (City, town, or county) (State)
<u>Frostburg, Md.</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Kight</u> | | | | | | ADDRESS
<u>Cumberland, Md.</u> | | | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. # **45204**

| | | | | | | | |
|---|--|--|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
<u>30 min.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS
<u>Route 5.</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>JAMES</u> Middle <u>E</u> Last <u>CAPEL</u> | | | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>8</u> Year <u>19 60</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 26, 1943</u> | |
| 9. AGE (In years last birthday)
<u>17</u> yrs. | | IF UNDER 1 YEAR
Months <u>17</u> Days <u>17</u> | | IF UNDER 24 HRS.
Hours <u>17</u> Min. <u>17</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>George A. Capel, Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elsie Dawson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>George Capel, Route 5, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u>
<u>816X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Skull Fracture</u>
DUE TO (c) <u>30 Minutes</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 Minutes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Automobile Accident MV - MV</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>3:00 p.m. May 8 1960</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Rt. 220 Rt. #5 Cumberland, Allegany, Maryland</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 8, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 11, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Frostburg Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Frostburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Kight</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>MAY 11 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAYLAND STATE DEPARTMENT OF HEALTH - EXAMINER'S CERTIFICATE OF DEATH

| | |
|---|--|
| DEATH NO. 1000000000 | |
| COUNTY 1000000000 | CITY 1000000000 |
| DECEASED'S NAME 1000000000 | |
| SEX 1000000000 | |
| AGE 1000000000 | |
| DATE OF BIRTH 1000000000 | |
| PLACE OF BIRTH 1000000000 | |
| OCCUPATION 1000000000 | |
| CAUSE OF DEATH 1000000000 | |
| MANNER OF DEATH 1000000000 | |
| SIGNATURE OF EXAMINER 1000000000 | |
| DATE 1000000000 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5208

CERTIFICATE OF DEATH

Reg. 15205

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | c. LENGTH OF STAY IN 1b
02 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
761 Fayette St., | | d. STREET ADDRESS
600 Washington St., | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Hattie Middle Cecelia Last Cavey | | 4. DATE OF DEATH
Month May Day 23 Year 19 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Dec. 31, 1871 |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife, | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John T. Miles | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No, | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Edward C. Cavey | | Address Cumberland, Md.
600 Washington St., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis
(c) Complications of age | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. _____
p. m. _____
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
Cumberland Alleg Md. | |
| 21. I certify that I attended the deceased from 3/17/52 , 19____, to 5/23/60 , 19____, that I last saw the deceased alive on 5/23/60 , 19____, and that death occurred at 5:00A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Richard J. Williams | | ADDRESS (Street, city or town, state)
122 So. Centre St., | |
| PHYSICIAN'S NAME (Type)
Richard J. Williams M.D. | | DATE SIGNED
5/23/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/26/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
DATE MAY 25 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5209

CERTIFICATE OF DEATH

05206
Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | | | c. LENGTH OF STAY IN 1b 6/7/55 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Ann Middle Ricker Last Coleman | | | | 4. DATE OF DEATH
Month May Day 19 , Year 19 60 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/22/1901 | |
| 9. AGE (In years lost, birthday) 59 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Frank Ricker | | | | 14. MOTHER'S MAIDEN NAME Mary Mills | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. INFORMANT P.O.Box 599 Address Cumberland, Md. | | | |
| ALLEGANY COUNTY INFIRMARY RECORDS | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Sclerosis
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c) Chronic Nephritis
INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 6/7/55 , 19___, to 5/19/60 , 19___, that I last saw the deceased alive on 6/18/60 , 19___, and that death occurred at 9:05A AM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | | | ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/19/60 | | | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | | | Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/21/1960 | | 22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | 22d. LOCATION (City, town, or county) (State) Lonaconing, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN ADDRESS LONA CONING? MD. | | | | 24a. REC'D BY REGISTRAR MAY 23 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



5205

STATE OF MARYLAND

5205

Allegany

Maryland

Allegany

Overland

6/17/55

Donning

Allegany County Jail

Ann

Ricker

Colman

May

60

White

2/22/1901

59

Housewife

Donning, Maryland

U. S. A.

Frank Ricker

Mary White

100000000

ALLEGANY COUNTY JAIL

Overland, Md.

6/17/55

6/17/55

6/16/50

8:55

19 June 55

5/15/50

Overland, Md.

Dr. James E. Tolson

6/17/55

ALLEGANY COUNTY JAIL

1
M
062

5210

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05207

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b <i>Life</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle J. Last COLEMAN | | | | 4. DATE OF DEATH
Month MAY Day 2nd Year 1960 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-26-1890 | |
| 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION? Give kind of work done during most of working life, even if retired <i>Retired Pharmacist</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Drug</i> | | | |
| 13. FATHER'S NAME WILLIAM COLEMAN | | | | 14. MOTHER'S MAIDEN NAME CATHERINE FRIELE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 217-10-493 | | 17. INFORMANT Mrs. Lousa Coleman Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
DUE TO <i>Coronary Thrombosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i>
DUE TO (c) <i>Arteriosclerosis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 hour</i>
<i>unk</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old Cerebral Vascular occlusion from Arteriosclerosis</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>Dec 19 59</i> to <i>30 April 19 60</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>30 April 19 60</i> and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>L. Michael Glick</i> | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) DR. L. GLICK. | | | | 22d. ADDRESS 126 N. Smallwood St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 5/6/60 | | 23c. NAME OF CEMETERY OR CREMATORY St. Valuck's Cem. | | 23d. LOCATION (City, town or county) (State) Cumberland Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stan Inc.</i> | | | | 25a. REC'D BY REGISTRAR DATE MAY 9 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> | |

ap

12303

2310



Handwritten signature

Handwritten text, mostly illegible due to bleed-through from the reverse side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5211 CERTIFICATE OF DEATH 05208

| | | | | | |
|---|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
1 HR. 45 MIN. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CRESAPTOWN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | / d. STREET ADDRESS
Craddock Road | |
| 3. NAME OF DECEASED (Type or print)
First GRACE Middle --- Last COX | | | 4. DATE OF DEATH
Month MAY Day 13 Year 19 60 | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV. 22, 1893 | | 9. AGE (In years last birthday)
66 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife, | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
PATTERSON CREEK, W.VA. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
SEYMOUR BALDWIN | | | 14. MOTHER'S MAIDEN NAME
MARY ABE | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL Address CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Aortic Valvular Deformity | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 Hours
5 1/2 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1958 to MAY 13, 1960 that (I) (we) last saw the deceased alive on 5/13 19 60 , and that death occurred at 4:15 PM M, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
S. G. Weisman | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/14/60 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. S. G. WEISMAN | | 22d. ADDRESS
59 GREENE ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/16/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | |
| 23d. LOCATION (City, town, or county) | | (State)
Cumberland, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Maryland | | 25a. REC'D BY REGISTRAR
DATE MAY 18 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Reese | | | | | |

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CHIEF ALVIN

MOORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5212

CERTIFICATE OF DEATH

05209

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
11 mo., 14 da. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | | d. STREET ADDRESS
734 Maryland Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sylvan Retreat | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle Grover Last Crawford | | 4. DATE OF DEATH
Month May Day 23 Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/4/85 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY
City of Cumberland Burlington, W. Va. | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Crawford | | 14. MOTHER'S MAIDEN NAME
Melissa Jane Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO.
213-24-6448 | |
| 17. INFORMANT
Institution Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331 Cerebral Hemorrhage
DUE TO 422 Myocardial Degeneration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450 General arteriosclerosis
DUE TO (c) 322 Chronic Alcoholism
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
48 hrs
?
? | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 14, 1959 , to May 23, 1960 , that I last saw the deceased alive on May 23, 1960 , and that death occurred at M , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
James E. McLean M.D. | | ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED May 31 '60 | |
| PHYSICIAN'S NAME (Type)
James E. McLean, M.D. | | 49 Greene St., Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
May 26, 1960 | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland. | | 24a. REC'D BY REGISTRAR
MAY 31 '60 24b. REGISTRAR'S SIGNATURE
William S. Kraus | |

CERTIFICATE OF DEATH

1918

1918

| | | | | | | | | | | | | | | | |
|------------------|--|------------|--|------------------|--|------------------|--|-------------------|--|---------------|--|----------------|--|----------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | COUNTY | | STATE | |
| JAMES H. HARRIS | | Male | | 45 | | Jan 15, 1873 | | Baltimore | | Maryland | | Baltimore | | Maryland | |
| MARRIAGE | | SINGLE | | MARRIED | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY | | COUNTY | | STATE | |
| None | | None | | None | | None | | None | | None | | None | | None | |
| EDUCATION | | SCHOOLING | | REASON FOR DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | |
| High School | | 12 | | Pneumonia | | Jan 25, 1918 | | Baltimore | | Maryland | | Baltimore | | Maryland | |
| OCCUPATION | | PROFESSION | | CAUSE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | |
| None | | None | | None | | None | | None | | None | | None | | None | |
| RELIGION | | RACE | | COLOR | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | |
| None | | White | | White | | Male | | 45 | | Jan 15, 1873 | | Baltimore | | Maryland | |
| EDUCATION | | SCHOOLING | | REASON FOR DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | |
| High School | | 12 | | Pneumonia | | Jan 25, 1918 | | Baltimore | | Maryland | | Baltimore | | Maryland | |
| OCCUPATION | | PROFESSION | | CAUSE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | |
| None | | None | | None | | None | | None | | None | | None | | None | |
| RELIGION | | RACE | | COLOR | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | |
| None | | White | | White | | Male | | 45 | | Jan 15, 1873 | | Baltimore | | Maryland | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT, UNLESS IT IS ACCOMPANIED BY A CERTIFICATE OF DEATH FROM THE FEDERAL GOVERNMENT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5215

45210

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital- D. O. A. | | | | d. STREET ADDRESS
29 Poplar St. Bowling Green | | | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Joann | | First
Bonita | | Last
Crawford | | 4. DATE OF DEATH
Month May Day 28 Year 19 60 | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 14, 1960 | |
| 9. AGE (In years last birthday)
1 14 | | IF UNDER 1 YEAR
Months 1 Days 14 | | IF UNDER 24 HRS.
Hours 14 Min. 14 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Charles E. Crawford | | | | 14. MOTHER'S MAIDEN NAME
Joyce Beedle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. C. E. Crawford, Bowling Green | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) AORTIC STENOSIS, PATENT FORAMEN OVALE
DUE TO
Conditions, if any, which gave rise to immediate cause (b) CONGENITAL ANOMALY
(c) 754.3
DUE TO
(c) 754.3
DUE TO
cause lost. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
since birth | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
ASPITATION OF STOMACH CONTENTS, MINIMAL, TERMINAL | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED MAY 28, 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 31, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Restlawn Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
JUN 1 1960 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

2060333XV3

STATE OF MARYLAND
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

3214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05211

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY MINERAL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
10 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ETTA Middle E Last DAVIS | | | | 4. DATE OF DEATH
Month MAY Day 23 Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 23, | |
| 9. AGE (In years last birthday)
83 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CHRISTOPHER HOTT | | 14. MOTHER'S MAIDEN NAME
HARRIET, GERARD | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MEMORIAL HOSPITAL | | Address
CUMBERLAND, MD. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
422.1 DUE TO Arteriosclerosis
(b) Complications, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Complications of Age
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. — p. m. — 19 | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
Cumberland, Allegany, Md. | | 21. I certify that (I) (this hospital) attended the deceased from 5/5/60 19 to 5/23/60 19, that (I) (we) last saw the deceased alive on 5/23/60 19, and that death occurred at 2:20 AM on the causes and on the date stated above. | |
| 22a. SIGNATURE
DR. R. J. WILLIAMS | | 22b. PHYSICIAN'S NAME (Type)
DR. R. J. WILLIAMS | | 22c. ADDRESS
122 SO. CENTRE STREET, CUMBERLAND, MD. | | 22d. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
MAY 25/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Philes Cemetery | | 23d. LOCATION (City, town, or county) (State)
Westernport, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. H. Fredlock Jr. | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Haines | | 25c. ADDRESS
Piedmont, W. Va. | |

CERTIFICATE OF DEATH

WEST VIRGINIA

DEPARTMENT OF HEALTH

ALLEGANY

DECEASED

IN DAYS

AT PLACE

127 E. HUNTING STREET

ALLEGANY HOSPITAL

ALLEGANY

DATE

AGE

CITY

SEX

BY

WHITE

DATE

West Virginia

REGISTERED

REGISTERED

ALLEGANY HOSPITAL

127 E. HUNTING STREET, ALLEGANY, W. VA.

DR. R. J. WILLIAMS

West Virginia

DECEASED

IN DAYS

AT PLACE

ALLEGANY

ALLEGANY HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5215 CERTIFICATE OF DEATH

05212

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 11 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HOWARD Middle J. Last DAVIS | | | | 4. DATE OF DEATH Month MAY Day 28 Year 19 60 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY 17 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) MAYSVILLE, W.VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | | | |
| 13. FATHER'S NAME GEORGE DAVIS | | | | 14. MOTHER'S MAIDEN NAME VINEY VICTORIA KEPLINGER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident (Embolus)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation
DUE TO (c) Coronary arterial sclerosis; Myocardial fibrosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days

??

?? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia; Peripheral vascular insufficiency, right | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 17 1960 , to May 28 1960 , that (I) (we) last saw the deceased alive on May 27 1960 , and that death occurred 7:15 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Samuel M. Jacobson | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED May 28, 1960 | |
| 22c. PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON, M. D. | | | | 22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 5/31/60 | | 23c. NAME OF CEMETERY OR CREMATORY Lahmansville Cem. | | 23d. LOCATION (City, town, or county) (State) Lahmansville W.Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE EL Back | | | | ADDRESS Westernport, md. | | 25a. REC'D BY REGISTRAR DATE JUN 3 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kline | | | |



WILLIAM

WILLIAM

11 JULY

11 JULY

MEMORIAL & MARRIAGE

MEMORIAL & MARRIAGE

DAVID

DAVID

JULY 17

JULY 17

WILLIAM, W. W.

WILLIAM, W. W.

VICTOR KOTLER

GEORGE DAVIS

MEMORIAL & MARRIAGE

Germany-vascular system (Schoen)

Germany-vascular system (Schoen)

Germany-vascular system (Schoen)

Germany-vascular system (Schoen)

11 JULY

11 JULY

11 JULY

11 JULY

11 JULY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05213**

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
1 Day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
43 Westernport | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial | | | | d. STREET ADDRESS
1 208 Vine | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First George Middle Washing Last Dayton | | | | 4. DATE OF DEATH
Month May Day 22 Year 19 60 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 26, 1878 | | 9. AGE (In years last birthday)
81 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George W. Dayton | | | | 14. MOTHER'S MAIDEN NAME
Fanny Cole | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Marshall Dayton-Westernport, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Gangrene of bowel
DUE TO
(c) Strangulated hernia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
3 days
----- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | May 22, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/24/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Philos | | 22d. LOCATION (City, town, or county) (State)
Westernport, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. Boral | | | | ADDRESS
Westernport, Md. | | 24a. REC'D BY REGISTRAR
MAY 25 60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5292

CERTIFICATE OF DEATH

05214

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Barton</u> | | | | c. LENGTH OF STAY IN 1b
<u>9 Yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
<u>/</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>Henry</u> Last <u>Deniker</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Mar. 8, 1888</u> | | 9. AGE (In years last birthday)
<u>72</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Edward Deniker</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Not Known</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>214-16-2009</u> | | 17. INFORMANT Address
<u>Alta D. Preston-Barton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Degeneration Not specified as Rheumatic</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>2 Years</u>
<u>5 Years</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>March 5, 1960</u> , to <u>May 4, 1960</u> , that I last saw the deceased alive on <u>May 3, 1960</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Paul R. Wilson</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>5-5-60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u> | | | | M.D. <u>H. Ashbie Id. St. Piedmont W.Va.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/6/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Salisbury Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Salisbury, Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>E. J. Bival</u> | | | | ADDRESS
<u>Westernport, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 6 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kenna</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

| | | | |
|---|--|---|--|
| DECEASED
NAME
LAST FIRST MIDDLE
(Print or Write) | | SEX
MALE FEMALE | |
| AGE
YEARS MONTHS DAYS
(Print or Write) | | DATE OF BIRTH
YEAR MONTH DAY
(Print or Write) | |
| PLACE OF BIRTH
(Print or Write) | | PLACE OF DEATH
(Print or Write) | |
| OCCUPATION
(Print or Write) | | CAUSE OF DEATH
(Print or Write) | |
| MANNER OF DEATH
(Print or Write) | | MEDICAL ATTENDANT
(Print or Write) | |
| SIGNATURE OF DECEASED
(Print or Write) | | SIGNATURE OF MEDICAL ATTENDANT
(Print or Write) | |
| SIGNATURE OF NEXT OF KIN
(Print or Write) | | SIGNATURE OF CORONER
(Print or Write) | |
| SIGNATURE OF REGISTRAR
(Print or Write) | | SIGNATURE OF CLERK
(Print or Write) | |



This certificate is to be filled out by the medical attendant or coroner in the case of a death occurring in the city of Baltimore, Maryland, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|-------------------------|-------------------|---|--|------------------|--|---|--------------------------------------|--|--|
| 5217 | | | | | 5215 | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE | | | | | | |
| ALLEGANY | | | | | MARYLAND | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| CUMBERLAND | | | | | 02 CUMBERLAND | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | 1 d. STREET ADDRESS | | | | | | |
| SACRED HEART HOSPITAL | | | | | 328 FAYETTE STREET | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | | | | 4. DATE OF DEATH | | | | | | |
| First Middle Last | | | | | Month Day Year | | | | | | |
| JOHN RANDOLPH DICK SR. | | | | | MAY 4 19 60 | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Sept. 26, 1872 | | 87 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Retired Electrician | | | | | Celanese Corp. | | MARYLAND | | U.S.A. | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| WILLIAM LIVINGSTON DICK | | | | | JANE PATRICK DICK | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| No | | 214-07-5002 | | Mrs. John Dick, 328 Fayette St. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Degeneration</u>
DUE TO (c) <u>Coronary Artery Disease</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>60</u> to <u>3/4</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>4/3</u> 19 <u>60</u> , and that death occurred <u>12:25 AM</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | 22b. DATE SIGNED | | | | | | |
| <u>DR. L.H. LEY</u> | | | | | 5/4/60 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | | | |
| DR. L.H. LEY | | | | | 456 N CENTER STREET | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town, or county) (State) | | | |
| Burial | | | May 6, 1960 | | St. Peter's Cemetery | | | Westernport, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Charles L. George, Cumberland, Md. | | | | | MAY 9 '60 | | Arthur S. Thomas | | | | |

1931

CERTIFICATE OF DEATH

1931



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5218

05216

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
13 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First LELIA Middle A. Last DICKERHOOF | | | | 4. DATE OF DEATH
Month MAY Day 18 Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 11, 1890 | |
| 9. AGE (In years lost birthdays)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
JOSEPH DEATELHAUSER | | | | 14. MOTHER'S MAIDEN NAME
MARY J. VALENTINE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
212-24-034 | | 17. INFORMANT
Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Hypertension Cordis
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular renal disease DUE TO
(c) (Uremia) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Since 1955 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7:20 to 5-18-1960 , that (I) (we) last saw the deceased alive on 5-18-1960 , and that death occurred at 6:22 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W.F. Williams | | | | 22b. DATE SIGNED
5-20-60 | | 22c. PHYSICIAN'S NAME (Type)
DR. W.F. WILLIAMS | |
| 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/21/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cem. | | 23d. LOCATION (City, town, or county) (State)
Cumberland MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc. | | | | 25a. REC'D BY REGISTRAR
MAY 23 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

CERTIFICATE OF DEATH

1918

AGE

SEX

RACE

EDUCATION

(10)

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE

TIME

PLACE OF DEATH

SEX

EDUCATION

WHITE

BLACK

TO

1918

CLEVELAND, OH.

MARY J. WELLS

LOCAL DEATH

CLEVELAND, OH.

IN MEMORIAL HOSPITAL

Handwritten notes and signatures, including a large signature and the date 1918.

(Seal)

1918

1918

1918

1918

Handwritten notes and signatures at the bottom of the page.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5219

CERTIFICATE OF DEATH

05217

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegheny</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>1606 Greene St.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>David</u> Last <u>Drobeck</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 26, 1892</u> | |
| 9. AGE (In years, last birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. | | IF UNDER 24 HRS. Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidate Home Equipment Corp.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>Benjamin Drobeck</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>214-05-4688</u> | | 17. INFORMANT <u>Evelyn H. Drobeck</u> | | Address <u>606 Greene St</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u>
DUE TO (b) <u>Acute anterior myocardial infarction</u>
DUE TO (c) <u>Coronary occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paroxysmal auricular tachycardia</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>60</u> , to <u>May 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>60</u> , and that death occurred at <u>9:12 A</u> . M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Samuel Jacobson</u> | | | | ADDRESS (Street, city or town, state) <u>50 Pershing Street</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M. D.</u> | | | | DATE SIGNED <u>5/24/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 24, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter & Paul Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> | | | | ADDRESS <u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAY 26 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | | | |

2152

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 5293
 CERTIFICATE OF DEATH

05218

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Ellerslie</u> | | | | c. LENGTH OF STAY IN 1b
<u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Charles Leroy Emerick</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>May 2, 1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 1, 1903</u> | 9. AGE (In years last birthday) yrs.
<u>56</u> | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Blacksmith</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>B&O Shops</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Ellerslie, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Sylvester Emerick</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Jeannette Speelman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-16-2211</u> | | 17. INFORMANT
Address
<u>Mrs. C.L. Emerick, Ellerslie, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA, CEREBRAL</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA</u>
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>2 WEEKS</u>
<u>6 MOS ?</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m.
Month, Day, Year
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
(County)
(State) | | | | |
| 21. I certify that I attended the deceased from <u>DEC</u> , 19 <u>59</u> , to <u>MAY</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>30 APRIL</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>441 N CENTRE ST</u> <u>5/3/60</u>
ACTUAL SIGNATURE <u>William P. James</u> M.D.
PHYSICIAN'S NAME (Type) <u>WILLIAM P. JAMES, M.D.</u> <u>CUMBERLAND, MD.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>May 5, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Palo Alto Cemetery</u> | 22d. LOCATION (City, town, or county)
<u>Hyndman, Pa. RD#1</u> | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Harvey L. Leigler</u>
ADDRESS
<u>Hyndman, Pa.</u> | | | 24a. REC'D BY REGISTRAR
DATE
<u>MAY 5 '60</u> | 24b. REGISTRAR'S SIGNATURE
<u>John J. Knauss</u> | | | |

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 Maryland State Department of Health
 Division of Statistical Research and Records — Baltimore 1, Maryland

5220

CERTIFICATE OF DEATH

05219

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD | | | | c. LENGTH OF STAY IN 1b
61 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MARYLAND | | | |
| f. STREET ADDRESS
500 LINDEN STREET | | | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) ROBERT ANDREW ENDRES | | | | 4. DATE OF DEATH
Month MAY Day 15 Year 1960 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 25, 1960 | |
| 9. AGE (In years last birthday)
1 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
ELMER ENDRES | | 14. MOTHER'S MAIDEN NAME
DORIS ANN NAVE | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Elmer Endres | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity and atelectasis
762.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Treacher Collins' Syndrome
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 11:20AM M, from the causes and on the date stated above. | |
| 22a. SIGNATURE
A. Hashim | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/16/60 | | 23c. NAME OF CEMETERY OR CREMATORY
P O S of A Cemetery | | 23d. LOCATION (City, town, or county) (State)
Centerville Penna | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ruth E. Silcox | | ADDRESS
Cumberland Maryland | | 25a. REC'D BY REGISTRAR
DATE MAY 19 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

2060242XV3



7280

CERTIFICATE OF DEATH

ALLICANY

WYLLAND

ALLICANY

WYLLAND

WYLLAND

WYLLAND

HOSPITAL MEMORIAL A. WYLLAND AVE. 500 CLICK STREET

HOSPITAL

WYLLAND

MAY 12, 1910

WYLLAND

MAY 12, 1910

WYLLAND

WYLLAND

WYLLAND

WYLLAND

WYLLAND

WYLLAND

WYLLAND

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5221 CERTIFICATE OF DEATH

05220

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
29 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First SHERIDAN Middle EVANS Last | | | | 4. DATE OF DEATH
Month MAY Day 14 Year 19 60 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
FEBRUARY 22 1881 | |
| 9. AGE (In years lost birthday)
79 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Months Days Hours Min. | | 12. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | | 10b. KIND OF BUSINESS OR INDUSTRY
ELK GARDEN, W.VA. | | | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
DAVID EVANS | | | | 14. MOTHER'S MAIDEN NAME
ARMEDA KESSEL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | | |
| 17. INFORMANT
WARWICK & MEMORIAL AVENUE | | | | 18. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
442X DUE TO
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) NEPHROSCLEROSIS
Hypertensive Cardiovascular Renal Disease | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6:00 A.M. MAY 14 1960 that (I) (we) last saw the deceased alive on MAY 13 1960 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
S. G. Weisman | | | | 22b. DATE SIGNED
5/14/60 | | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. S. G. WEISMAN | | | | 22d. ADDRESS
59 E. Green St. Cumberland Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/16/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos | | 23d. LOCATION (City, town, or county) (State)
Westernport Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
E. J. Boal | | | | 25. REC'D BY REGISTRAR
DATE MAY 17 '60 | | | |
| 25a. REGISTRAR'S SIGNATURE
Arthur S. Hanes | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanes | | | |

1982

CERTIFICATE OF DEATH

1982

1

ALLIANCE

MARYLAND

ALLIANCE

WESTERPORT

SR 0412

CLERKLAND

111 BOND STREET

RECEIVED HOSPITAL

NY

EVING

2:11 PM

RECEIVED SR

WHITE

111

0.0.1.

ELK GROVE, N.Y.

RECEIVED

DAVID L. L. L.

RECEIVED HOSPITAL

RECEIVED HOSPITAL

RECEIVED HOSPITAL - CLERKLAND, MARYLAND

1

RECEIVED HOSPITAL

RECEIVED HOSPITAL

RECEIVED HOSPITAL

RECEIVED HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8
M
062
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5222
CERTIFICATE OF DEATH
05221

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
80 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | | | d. STREET ADDRESS
879 M Patterson Ave., | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle Patrick Last FAIR | | | | 4. DATE OF DEATH
Month MAY Day 23 Year 1960 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 4, 1879 | |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mill worker | | 11. BIRTHPLACE (State or foreign country)
Midland, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William Fair | | 14. MOTHER'S MAIDEN NAME
Kathryn Moody | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No. | |
| 16. SOCIAL SECURITY NO.
214-07-0198 | | 17. INFORMANT
Mrs. Catherine Hausrath | | Address Cumb. Md.
515 Washington St | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio vascular disease
DUE TO 422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
4 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 12-19 19 57 to 5-23-60 19, that (I) (we) last saw the deceased alive on 5-22-60 19, and that death occurred at 7:30 P.M. from the causes and on the date stated above. | | 22a. SIGNATURE
R.W. Ballin | |
| 22b. DATE SIGNED
5-23-60 | | 22c. PHYSICIAN'S NAME (Type)
DR. R.W. BALLIN | | 22d. ADDRESS
62 GREENE STREET | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/25/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Belvidiere Cem. | | 23d. LOCATION (City, town, or county) (State)
Midland, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 25 1960 | | 25b. REGISTRAR'S SIGNATURE
Charles S. Hines | |

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CONFIDENTIAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05222
Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
<u>years</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>542 Fort Avenue</u> | | | | d. STREET ADDRESS
<u>542 Fort Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>CARTER HENRY GALLIHER</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>MAY 8 19 60</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Dec. 28, 1903</u> | |
| 9. AGE (In years last birthday)
<u>56</u> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Blacksmith Helper</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>B & O Railroad</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>Morgan County, West Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>SAMUEL B. GALLIHER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY ELLEN FAHEY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>705-07-9679</u> | | 17. INFORMANT
<u>Mrs. Evelyn Galliher</u> Address <u>542 Fort Avenue, Cumberland, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxiation, due to Hanging</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(c) _____
DUE TO
(a) stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 MIN.</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>May 8 1960</u>
Hour <u>1:00</u> a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State)
<u>Cumberland Allegany Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 8, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/11/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | | 24a. REC'D BY REGISTRAR
<u>MAY 16 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Benedict J. Skitarelic</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARTIN LUTHER KING, JR. - CIVIL RIGHTS LEADER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5224

CERTIFICATE OF DEATH

05223
Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegheny</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>02</u> <u>Cumberland</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>222 Wills Creek Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Frank</u> Middle <u>J.</u> Last <u>Gellner</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>26</u> Year <u>1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 5, 1883</u> |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Glass Blower</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Mfg. Glassware</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John M. Gellner</u> | | 14. MOTHER'S MAIDEN NAME
<u>Anna M. Miller</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>219-03-8122</u> | |
| 17. INFORMANT
<u>Mrs. Rita V. Burke</u> | | Address
<u>Cumberland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>163X Carcinoma of Lung, right side</u>
DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 Months</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>January 1960</u> to <u>May 25, 1960</u> , that I last saw the deceased alive on <u>May 25, 1960</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>J. J. J. J. J.</u> | | ADDRESS (Street, city or town, state)
<u>16900 St. Clair, Md.</u> | |
| PHYSICIAN'S NAME (Type)
<u>J. J. J. J. J.</u> | | DATE SIGNED
<u>May 25, 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 30, 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Peter & Paul Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Louis Stein, Inc.</u> | | ADDRESS
<u>Cumberland, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>MAY 31 60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. J. J.</u> | |

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|---------------|--|
| PLACE OF DEATH | | DATE OF DEATH | |
| HOME | | JAN 10 1918 | |
| DECEASED | | JAN 10 1918 | |
| NAME OF DECEASED | | JAN 10 1918 | |
| AGE | | JAN 10 1918 | |
| SEX | | JAN 10 1918 | |
| RACE | | JAN 10 1918 | |
| BIRTH | | JAN 10 1918 | |
| MARRIAGE | | JAN 10 1918 | |
| EDUCATION | | JAN 10 1918 | |
| OCCUPATION | | JAN 10 1918 | |
| CAUSE OF DEATH | | JAN 10 1918 | |
| MANNER OF DEATH | | JAN 10 1918 | |
| SIGNATURE OF DECEASED | | JAN 10 1918 | |
| SIGNATURE OF WITNESS | | JAN 10 1918 | |
| SIGNATURE OF PHYSICIAN | | JAN 10 1918 | |
| SIGNATURE OF CLERK | | JAN 10 1918 | |
| SIGNATURE OF JUDGE | | JAN 10 1918 | |
| SIGNATURE OF SHERIFF | | JAN 10 1918 | |
| SIGNATURE OF CORONER | | JAN 10 1918 | |
| SIGNATURE OF JURY | | JAN 10 1918 | |
| SIGNATURE OF COURT | | JAN 10 1918 | |
| SIGNATURE OF STATE | | JAN 10 1918 | |
| SIGNATURE OF NATION | | JAN 10 1918 | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05224

65984

| | | | | | | | | | | | | | | | |
|---|--|-------------------------------------|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
c. LENGTH OF STAY IN 1b <u>48yrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Sacred Heart Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Triple Lake R.D.#5</u>
d. STREET ADDRESS <u>Triple Lake</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Don Daniel Haan</u> | | | | 4. DATE OF DEATH Month Day Year
<u>May 21 1960</u> | | | | | | | | | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 21, 1889</u> | | 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Lumber Inspector</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Planing Mill</u> | | | | 11. BIRTHPLACE (State or foreign country)
<u>Luxembourg, Grand Duchy</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Michael Haan</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Teresa Ingle</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>214-05-6952</u> | | | | 17. INFORMANT Address
<u>Elsie E. Haan Triple Lake, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>
 DUE TO <u>CORONARY SCLEROSIS</u>
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH
 <u>Sudden</u>
 <u>24</u> --- </div> </div> | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) <u>24</u> (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 21, 1960</u> | | | | | | DATE SIGNED | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>5-24-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park Cumberland, Md.</u> | | | | 22d. LOCATION (City, town, or county) (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
<u>James F. Scarpelli Cumberland, Md</u> | | | | | | | | | | | | | | | |
| 24a. REC'D BY REGISTRAR | | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. House</u> | | | | | | | | | |
| DATE <u>MAY 24 '60</u> | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5226

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5227 *Item 14 Film G263 5-20-60 et* **05226**
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
25yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
319 Broadway | | | | d. STREET ADDRESS
319 Broadway | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle L. Last Harden | | | | 4. DATE OF DEATH
Month May Day 17 Year 1960 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept 15, 1895 | | 9. AGE (In years last birthday)
64 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY
Hospital | | 11. BIRTHPLACE (State or foreign country)
Greenburg, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Perry Harden | | | | 14. MOTHER'S MAIDEN NAME
Celia Kelly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-03-8727 | | 17. INFORMANT
Lillian Harden Address 319 Broadway | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO congestive heart failure
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
 (b) arteriosclerotic heart disease DUE TO
 (c) arteriosclerosis</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH
6 mo
1 year</p> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-3 , 19 59 , to 5-17 , 19 60 , that I last saw the deceased alive on 5-15 , 19 60 , and that death occurred at M , from the causes and on the date stated above.
<div style="display: flex; justify-content: space-between;"> <div> <p>ACTUAL SIGNATURE L. Brings</p> <p>PHYSICIAN'S NAME (Type) Lewis Brings</p> </div> <div> <p>ADDRESS (Street, city or town, state) 57 Green Street</p> <p>DATE SIGNED Cumberland Md</p> </div> </div> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-20-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli ADDRESS Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
DATE MAY 19 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05227**

| | | | | | | | |
|---|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
<u>65 years</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS
<u>11 N. Waverley Terrace</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>WILLIAM</u> Middle <u>NEVIN</u> Last <u>HAY</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 8, 1875</u> | | 9. AGE (In years last birthday)
<u>84</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Bookkeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Dairy</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Nebraska</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Calvin Hay</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Drucilla DeVore</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>214 05 4548</u> | | 17. INFORMANT Address
<u>Mrs. John Carroll</u> <u>Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, Left</u>
 DUE TO
 Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio-Vascular disease</u>
 (c), stating the underlying cause lost. DUE TO _____ </div> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 23, 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 25, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Patricks Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
<u>Byron Kight</u> <u>Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR
<u>MAY 24 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kneiss</u> | |

MEDICAL CERTIFICATION

 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5279

CERTIFICATE OF DEATH

05228

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frostburg,</u> | | | | c. LENGTH OF STAY IN 1b
<u>2 weeks</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Miner's Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Grace</u> Middle <u>Henckel</u> Last <u>Henckel</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>17th</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 9th, 1884</u> | |
| 9. AGE (In years last birthday)
<u>75</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. telegraph Operat.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>W.Md.R.R.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Valentine Henckel</u> | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Snyder</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>705-10-7835</u> | | 17. INFORMANT
<u>Glen Savage Road, Miss Edna Henckel, Mt. Savage, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u>
DUE TO <u>241X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>3 mo</u>
<u>many years</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 17, 1959</u> to <u>May 17, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1960</u> and that death occurred at <u>8:10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W. O. McLane</u> | | | | 22b. DATE SIGNED
<u>May 8 1960</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>W. O. McLane</u> | |
| 22d. ADDRESS
<u>167 E. Main St., Frostburg, Md.</u> | | | | 22e. ADDRESS
<u>"</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5-20-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Patrick's Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Mt. Savage, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>J. R. Durst</u> | | | | ADDRESS
<u>Frostburg, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 20 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles S. Hance</u> | | | | 25c. REGISTRAR'S SIGNATURE
<u>Charles S. Hance</u> | | | |

8338

5278

MINISTRE DU TRAVAIL ET DES REVENUS
CENTRE DE LA CROIX-ROUGE
MONTREAL

ATTENTION

ATTENTION

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5229

CERTIFICATE OF DEATH

05229
Reg. Dist. No.

| | | | | | | | | |
|--|--|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
<u>90</u> years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02</u> <u>Cumberland</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>228 Pear Street</u> | | | | d. STREET ADDRESS
<u>228 Pear Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>HERPICH</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>20</u> Year <u>19 60</u> | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb. 23, 1863</u> | | |
| 9. AGE (In years last birthday)
<u>97</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Edward Rice</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Caroline ?</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Mrs. Lester Barnes</u> | | Address
<u>Cumberland, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>uraemia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>25 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. _____ p. m. _____
19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that I attended the deceased from <u>June, 1954</u> , to <u>May 20, 1960</u> , that I last saw the deceased alive on <u>May 10, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE
<u>Clayton S. Surratt</u> | | M.D. <u>23660 Pear Cumberland</u> | | DATE SIGNED
<u>5/21/60</u> | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 23, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) _____ (State) _____
<u>Cumberland, Md.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Kight</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 24 '60</u> | | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kline</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

| | | | | | | | | | | | |
|------------------------|--|-------------------------|--|--------------------------|--|-------------------|--|----------------|--|-------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 15 1883 | | BALTIMORE, MD. | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JUN 15 1905 | | BALTIMORE, MD. | | MARY H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | |
| OCCUPATION | | DATE OF OCCUPATION | | PLACE OF OCCUPATION | | NAME OF EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | |
| LABORER | | JUN 15 1928 | | BALTIMORE, MD. | | BALTIMORE, MD. | | JUN 15 1928 | | BALTIMORE, MD. | |
| CAUSE OF DEATH | | DATE OF CAUSE OF DEATH | | PLACE OF CAUSE OF DEATH | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JUN 15 1928 | | BALTIMORE, MD. | | DR. J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | |
| MANNER OF DEATH | | DATE OF MANNER OF DEATH | | PLACE OF MANNER OF DEATH | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JUN 15 1928 | | BALTIMORE, MD. | | DR. J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | |
| DATE OF DEATH | | PLACE OF DEATH | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | | NAME OF PHYSICIAN | |
| JUN 15 1928 | | BALTIMORE, MD. | | DR. J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | | DR. J. H. HARRIS | |
| SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | | DR. J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | |
| SIGNATURE OF REGISTRAR | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | NAME OF REGISTRAR | | DATE OF DEATH | | PLACE OF DEATH | |
| J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | | DR. J. H. HARRIS | | JUN 15 1928 | | BALTIMORE, MD. | |



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

STATE OF MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5294

05230

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Eckhart | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Parkersburg Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Emory Last Humbertson | | | | 4. DATE OF DEATH Month May Day 7th , Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 22nd, 1902 | |
| 9. AGE (In years lost birthday) 57 yrs. | | IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. | | IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Eck. Coal Mine | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Jerome Humbertson | | | | 14. MOTHER'S MAIDEN NAME Elva Porter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. 217-09-5421 | | 17. INFORMANT Parkersburg Road, Mrs. Lester Rephann, Eckhart, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Stomach.
151X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary anemia.
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 4-6 mos
6 mos. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-1 , 19 60 to 5-7 , 19 60 , that (I) (we) last saw the deceased alive on 5-7 , 19 60 , and that death occurred at 7A M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE H. C. Diehl | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/9/60 | |
| 22c. PHYSICIAN'S NAME (Type) H. C. Diehl, | | | | 22d. ADDRESS 39 W. Main St., Frostburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-10-60 | | 23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery, | | 23d. LOCATION (City, town, or county) (State) Eckhart, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst | | | | ADDRESS Frostburg, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 11 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles E. Hume | | | |

10320

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
STATE OF NEW YORK
CERTIFICATE OF DEATH

11

1. Name of deceased: Johnston, Robert
2. Sex: Male
3. Age: 35
4. Date of birth: May 15, 1893
5. Place of birth: Brooklyn, N.Y.
6. Date of death: May 15, 1928
7. Place of death: Brooklyn, N.Y.
8. Cause of death: Heart disease
9. Signature of physician: [Signature]
10. Signature of registrar: [Signature]
11. Date of registration: May 16, 1928
12. Office of registration: Brooklyn, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05231
Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CUMBERLAND</u> | | | c. LENGTH OF STAY IN 1b
<u>45 minutes</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SACRED HEART HOSPITAL</u> | | | | /d. STREET ADDRESS
<u>209 GREENE STREET</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>ALFRED</u> Middle <u>JACOPI</u> Last <u>JACOPI</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>2</u> Year <u>1960</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1-14/05</u> | |
| 9. AGE (In years last birthday)
<u>55</u> yrs. | | IF UNDER 1 YEAR
Months <u>5</u> Days <u>2</u> | | IF UNDER 24 HRS.
Hours <u>6</u> Min. <u>00</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Grocery Owner</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>Grocery</u> | | | | 11. BIRTHPLACE (State or foreign country)
<u>ITALY</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>ANGELO JACOPI</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Agusta Bastiani</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u></u> | | 17. INFORMANT Address
<u>Mrs Alfred Jacopi 209 Greene St.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1 Coronary Sclerosis with thrombosis, right</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular disease</u>
(a), stating the underlying cause last. DUE TO (c) <u></u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Also old left myocardial infarction due to sclerosis of left artery.</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs.</u></p> </div> </div> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u></u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u></u> a. m. <u></u> p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u></u> | | 20f. (City or town) (County) (State)
<u></u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>May 2, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/2/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>S. S. Peter & Paul's</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George, Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles L. George</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

VS. A15ME(5)
SM 9/55

MARTIN STATE DEPARTMENT OF HEALTH-BALTIMORE 78

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5288

CERTIFICATE OF DEATH

05232

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | | | | c. LENGTH OF STAY IN 1b
X | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Douglas Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First James Middle Jones Last Jones | | | | 4. DATE OF DEATH
Month May Day 27 Year 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 8, 1904 | |
| 9. AGE (In years lost birthday)
55 yrs. | | 10. IF UNDER 1 YEAR
Months 55 Days 55 Hours 55 Min. | | 11. BIRTHPLACE (State or foreign country)
Lonaconing, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Celanease Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME
Edward Jones | | | | 14. MOTHER'S MAIDEN NAME
Rose Clark | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Mrs. James Jones Address Lonaconing, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Acute myocardial failure
DUE TO (b) Coronary artery disease
DUE TO (c) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
24 hrs
years
years | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
MD | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 to 5-27 19 60 that (I) (we) last saw the deceased alive on 5-27 19 60 , and that death occurred at 9 a.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
L.R. Miles, Jr. | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
L.R. MILES, JR., M.D. | | | | 22d. ADDRESS
LONAICONING MD | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | 23b. DATE THEREOF
5/30/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 23d. LOCATION (City, town, or county) (State)
Moscow, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | | | ADDRESS
Lonaconing, Md. | | 25a. REC'D BY REGISTRAR
JUN 1 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



128

STATE OF DEAL

Alimony

Married

Alimony

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Longshore

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[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

5280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05233

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS H anekamp, St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LESLIE Middle M. Last JONES | | 4. DATE OF DEATH Month 5/25/ Day 1960 Year 19 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/6/ 1894 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Lonaconing, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward Jones | | 14. MOTHER'S MAIDEN NAME Rose Clark | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-05-5806 | |
| 17. INFORMANT Mrs. Leslie Jones, Lonaconing, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
450.0 IMMEDIATE CAUSE (a) Acute myocardial failure
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis, Bronchial asthma, Emphysema | | | |
| INTERVAL BETWEEN ONSET AND DEATH 36 hours
years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1959 to May 25, 1960 , that (I) (we) last saw the deceased alive on May 25, 1960 and that death occurred at 3 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE L. R. Miles, Jr. | | 22b. DATE SIGNED 5-26-60 | |
| 22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D. | | 22d. ADDRESS Lonaconing Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/28/1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | 23d. LOCATION (City, town, or county) (State) Lonaconing, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Md. | | 25a. REC'D BY REGISTRAR MAY 27 '60 | |
| 25b. REGISTRAR'S SIGNATURE Charles L. Hester | | | |

CERTIFICATE OF DEATH

1920

1/1/20

London

1/1/20

London

1/1/20

London

1/1/20

1/1/20

1/1/20

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1/1/20

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5231

05234

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
7 DAYS | | | |
| d. NAME OF HOSPITAL (If in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVE. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle P. Last KAYLOR | | | | 4. DATE OF DEATH
Month MAY Day 6 Year 19 60 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APRIL 2 1897 | |
| 9. AGE (In years lost birthday)
63 yrs. | | 10. UNDER 1 YEAR
Months 63 Days 63 Hours 63 Min. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND Towncreek | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Car Formen | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | | |
| 13. FATHER'S NAME
ADAM KAYLOR | | | | 14. MOTHER'S MAIDEN NAME
ANNE LARGENT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
710-09-6100 | | 17. INFORMANT
MEMORIAL HOSPITAL CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thromboses
DUE TO 322X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Generalized Vascular Disease
DUE TO Arteriosclerosis
(c) Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH
1 week | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 19
p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/7/60 19 to 5/6/60 19 that (I) (we) last saw the deceased alive on 5/6/60 and that death occurred at 9:01 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
R. J. Williams | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. R.J.WILLIAMS | | | | 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-9-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | | | 25a. REC'D BY REGISTRAR
MAY 11 '60 | | | |
| ADDRESS
Cumberland, Md. | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kneass | | | |

USCIB

CERTIFICATE OF DEATH

1931

DECEASED

DECEASED

DECEASED

DATE OF DEATH

DATE

DATE

PLACE OF DEATH

PLACE OF DEATH

SEX

SEX

SEX

AGE

AGE

AGE

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

[Faint, mostly illegible text in the lower half of the page, likely containing details of the deceased and the certifying physician.]

5232

CERTIFICATE OF DEATH

05235

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR Allegany County Infirmary | | d. STREET ADDRESS Nat'l Highway, Narrows Park | |
| 3. NAME OF DECEASED (Type or print) Mary Henrietta Keller | | 4. DATE OF DEATH Ma 9 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/14/75 |
| 9. AGE (In years last birthday) 85 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard Bender | | 14. MOTHER'S MAIDEN NAME Mary Gesner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT P.O. Box 599 | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocarditis
DUE TO cerebral arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic nephritis
DUE TO (c) Severe psychosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/23/58 , 19____, to 5/8/60 , 19____, that I last saw the deceased alive on 5/8/60 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean | | ADDRESS (Street, city or town, state) 49 Greene St. | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | DATE SIGNED 5/9/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 11, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR MAY 11 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2332

2332

Allegany

Allegany

Allegany

Allegany

Allegany County, Maryland

Keller

Mary

Allegany

Allegany

Female

Housewife

Allegany

Allegany

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Allegany County, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5233

CERTIFICATE OF DEATH

05236

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
10 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
WARWICK & MEMORIAL HIGH AVENUES | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ELLA Middle Jane Last KERNS | | | | 4. DATE OF DEATH
Month MAY Day 14 Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
SEPTEMBER 25, 1881 | |
| 9. AGE (In years last birthday)
78 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Moses ROBINSON | | | | 14. MOTHER'S MAIDEN NAME
MARY MALONE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular disease
DUE TO (c) for advanced | | | | INTERVAL BETWEEN ONSET AND DEATH
Since 7-4-53 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-4-53 to 5-14-60 , that (I) (we) last saw the deceased alive on 5-14-60 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Wm F. Williams | | | | 22b. DATE
5-16-60 | | 22c. PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | |
| 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
5/16/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Bethel Cemetery | |
| 23d. LOCATION (City, town, or county) (State)
Bedford Valley, Penna. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 18 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hays | | | | | | | |

1333

CERTIFICATE OF DEATH

233

ALLIANCE

MARYLAND

ALLIANCE

COLUMBIAN

10 DAYS

COLUMBIAN

22 W. LINDEN STREET

MEMORIAL HOSPITAL

1912

1912

1912

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

1912



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5234

CERTIFICATE OF DEATH

05237

| | | | | | | | |
|---|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
8 HRS. 9 MIN. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First BABY Middle BOY Last KLINK | | | | 4. DATE OF DEATH
Month MAY Day 1 Year 19 60 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 1, 1960 | | 9. AGE (In years last birthday)
yrs. 8 Min. 9 | IF UNDER 1 YEAR
Months 8 Days 9 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ROBERT T. KLINK | | | | 14. MOTHER'S MAIDEN NAME
HELEN G. LEHR | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL | | Address
CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia Neonatorum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Asthenia + Aspiration Aelectasis
DUE TO
(c) Post Maturity? | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Manth. Day. Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 May 1960 to 1 May 1960 , that (I) (we) last saw the deceased alive on 1 May 1960 , and that death occurred 9:05P , from the causes and on the date stated above. | | | | | | | |
| 22. SIGNATURE
Leland Ransom | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
DR. LELAND RANSOM | | | | 22d. ADDRESS
63 GREENE ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/2/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Johnson Cemetery | | 23d. LOCATION (City, town, or county) (State)
Near Frostburg, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Haas | |

2060293XV4

CERTIFICATE OF DEATH

2338

(NAME OF DECEASED)

(AGE)

(SEX)

(RACE)

(PLACE OF BIRTH)

(DATE OF BIRTH)

(TIME OF BIRTH)

(PLACE OF BIRTH)

(DATE OF DEATH)

(TIME OF DEATH)

(PLACE OF DEATH)

(CAUSE OF DEATH)

(MANNER OF DEATH)

(SIGNATURE OF PHYSICIAN)

(SIGNATURE OF REGISTRAR)

(SIGNATURE OF WITNESSES)

(DATE)

(TIME)

(PLACE OF DEATH)

(CAUSE OF DEATH)

(SIGNATURE OF REGISTRAR)

(SIGNATURE OF WITNESSES)

(DATE)

(TIME)

(PLACE OF DEATH)

(CAUSE OF DEATH)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5281

CERTIFICATE OF DEATH

05238

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | | | c. LENGTH OF STAY IN lb
Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miner's Hospital | | | | /d. STREET ADDRESS
70 S. Water Street | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Elizabeth Last Koegel | | | | 4. DATE OF DEATH
Month May Day 20th , Year 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 3rd, 1886 | |
| 9. AGE (In years lost birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own housework | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
John Geis | | | | 14. MOTHER'S MAIDEN NAME
Julia Lapp | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
I | | | | 16. SOCIAL SECURITY NO.
217-30-1309B | | 17. INFORMANT
J.C. Koegel, 70 S. Water St., F'bg. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma
DUE TO (b) Left Ovary
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c)
175.0 | | | | INTERVAL BETWEEN ONSET AND DEATH
1 year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1959 to May 20, 1960 , that (I) (we) last saw the deceased alive on May 20, 1960 and that death occurred on May 20, 1960 at 5:15 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W O McLane | | | | 22b. DATE SIGNED
May 21, 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type)
W. O. McLane, | | | | 22d. ADDRESS
167 E. Main St., Frostburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-23-60 | | 23c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | | 23d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J P Ours | | | | 25a. REC'D BY REGISTRAR
MAY 23 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. House | |

(M)

1931

CERTIFICATE OF DEATH

1931

Allegany

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Allegany

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5295
 DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05239

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
65 years | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
34 Weber Street | | | | d. STREET ADDRESS
34 Weber Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Carl Middle Hodgson Last Koerner | | | | 4. DATE OF DEATH
Month May Day 14 Year 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb 20, 1895 | |
| 9. AGE (In years lost birthday)
65 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O R. R. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
F. S. Koerner | | | | 14. MOTHER'S MAIDEN NAME
Susan Gregg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
705-05-9457 | | 17. INFORMANT
Mrs. Nellie Koerner 34 Weber Street, Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO 9 yrs
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH Immediate | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
_____ | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. _____ p. m. _____ '19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
_____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/7/52 19____ to 5/14/60 19____, that (I) (we) last saw the deceased alive on 5/10/60 19____, and that death occurred at 5a M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Richard J. Williams, M.D. | | | | 22b. DATE
5/16/60 | | 22c. PHYSICIAN'S NAME (Type)
Richard J. Williams, M.D. | |
| 22d. ADDRESS
122 S. Centre St. Cumberland, Md. | | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/17/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Rosehill Cemetery | | 23d. LOCATION (City, town, or county) Cumberland (State) Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ruth E. Silcox | | | | 25a. REC'D BY REGISTRAR
MAY 20 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Heas | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05240

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN lb
<u>1 day</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Allegany County Infirmary</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>JESSIE</u> First <u>A. LASHBAUGH</u> Middle Last | | 4. DATE OF DEATH
Month <u>5</u> Day <u>13</u> Year <u>1960</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-29-22</u> |
| 9. AGE (In years last birthday)
<u>37</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Harry Mills</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Edna Cox</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> | |
| 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Mrs. Charles Robertson, Mt. Savage, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema; Pericardial Effusion</u>
DUE TO
Conditions, if only, which gave rise to immediate cause (b) <u>Mitral Stenosis, Marked</u>
(c) <u>Rheumatic Carditis and valvulitis, old.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
<u>8-10 Hrs.</u>
<u>years</u>
<u>years</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>19</u> o. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-16-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Methodist Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Mt. Savage Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Paul H. Whitesant</u> | | 24a. REC'D BY REGISTRAR
<u>May 20 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | DATE <u>MAY 20 '60</u> | |

15240

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED
JAMES J. HARRIS | | 2. SEX
Male | | 3. AGE
45 | |
| 4. DATE OF DEATH
April 10, 1933 | | 5. PLACE OF DEATH
Home | | 6. STREET ADDRESS
1234 N. E. St. | |
| 7. CITY
Baltimore | | 8. COUNTY
Baltimore | | 9. STATE
Maryland | |
| 10. OCCUPATION
Carpenter | | 11. MARITAL STATUS
Married | | 12. EDUCATION
High School | |
| 13. PRESENT ILLNESS
Myocardial Infarction | | 14. PREVIOUS ILLNESSES
Hypertension | | 15. CAUSE OF DEATH
Myocardial Infarction | |
| 16. MANNER OF DEATH
Natural | | 17. SIGNATURE OF EXAMINER
J. H. Smith | | 18. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 19. DATE OF EXAMINATION
April 10, 1933 | | 20. TIME OF EXAMINATION
10:00 AM | | 21. PLACE OF EXAMINATION
Home | |
| 22. SIGNATURE OF DECEASED
James J. Harris | | 23. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 24. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 25. DATE OF EXAMINATION
April 10, 1933 | | 26. TIME OF EXAMINATION
10:00 AM | | 27. PLACE OF EXAMINATION
Home | |
| 28. SIGNATURE OF DECEASED
James J. Harris | | 29. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 30. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 31. DATE OF EXAMINATION
April 10, 1933 | | 32. TIME OF EXAMINATION
10:00 AM | | 33. PLACE OF EXAMINATION
Home | |
| 34. SIGNATURE OF DECEASED
James J. Harris | | 35. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 36. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 37. DATE OF EXAMINATION
April 10, 1933 | | 38. TIME OF EXAMINATION
10:00 AM | | 39. PLACE OF EXAMINATION
Home | |
| 40. SIGNATURE OF DECEASED
James J. Harris | | 41. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 42. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 43. DATE OF EXAMINATION
April 10, 1933 | | 44. TIME OF EXAMINATION
10:00 AM | | 45. PLACE OF EXAMINATION
Home | |
| 46. SIGNATURE OF DECEASED
James J. Harris | | 47. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 48. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 49. DATE OF EXAMINATION
April 10, 1933 | | 50. TIME OF EXAMINATION
10:00 AM | | 51. PLACE OF EXAMINATION
Home | |
| 52. SIGNATURE OF DECEASED
James J. Harris | | 53. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 54. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 55. DATE OF EXAMINATION
April 10, 1933 | | 56. TIME OF EXAMINATION
10:00 AM | | 57. PLACE OF EXAMINATION
Home | |
| 58. SIGNATURE OF DECEASED
James J. Harris | | 59. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 60. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 61. DATE OF EXAMINATION
April 10, 1933 | | 62. TIME OF EXAMINATION
10:00 AM | | 63. PLACE OF EXAMINATION
Home | |
| 64. SIGNATURE OF DECEASED
James J. Harris | | 65. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 66. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 67. DATE OF EXAMINATION
April 10, 1933 | | 68. TIME OF EXAMINATION
10:00 AM | | 69. PLACE OF EXAMINATION
Home | |
| 70. SIGNATURE OF DECEASED
James J. Harris | | 71. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 72. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 73. DATE OF EXAMINATION
April 10, 1933 | | 74. TIME OF EXAMINATION
10:00 AM | | 75. PLACE OF EXAMINATION
Home | |
| 76. SIGNATURE OF DECEASED
James J. Harris | | 77. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 78. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 79. DATE OF EXAMINATION
April 10, 1933 | | 80. TIME OF EXAMINATION
10:00 AM | | 81. PLACE OF EXAMINATION
Home | |
| 82. SIGNATURE OF DECEASED
James J. Harris | | 83. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 84. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 85. DATE OF EXAMINATION
April 10, 1933 | | 86. TIME OF EXAMINATION
10:00 AM | | 87. PLACE OF EXAMINATION
Home | |
| 88. SIGNATURE OF DECEASED
James J. Harris | | 89. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 90. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 91. DATE OF EXAMINATION
April 10, 1933 | | 92. TIME OF EXAMINATION
10:00 AM | | 93. PLACE OF EXAMINATION
Home | |
| 94. SIGNATURE OF DECEASED
James J. Harris | | 95. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 96. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |
| 97. DATE OF EXAMINATION
April 10, 1933 | | 98. TIME OF EXAMINATION
10:00 AM | | 99. PLACE OF EXAMINATION
Home | |
| 100. SIGNATURE OF DECEASED
James J. Harris | | 101. SIGNATURE OF NEXT OF KIN
Mrs. J. H. Harris | | 102. SIGNATURE OF WITNESSES
J. H. Smith, J. D. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5237

05241

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
24 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | d. STREET ADDRESS
806 Washington St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Alice Middle ----- Last Laughlin | | 4. DATE OF DEATH
Month May Day 26 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 24, 1878 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Grafton, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Patrick J. Flannery | | 14. MOTHER'S MAIDEN NAME
Mary Langley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. J. Howard Welsh | | Address Cumb. Md. 806 Washington St., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease
420.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Bronchitis DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
years
year | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 19 60 to May 26 , 19 60 that (I) (we) last saw the deceased alive on May 26 , 19 60 , and that death occurred at 10:00AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
B. M. Schindler | | 22b. DATE SIGNED
5/27/60 | |
| 22c. PHYSICIAN'S NAME (Type)
Blaine M. Schindler | | 22d. ADDRESS
43 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/28/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Deer Park Cem. | | 23d. LOCATION (City, town, or county) (State)
Deer Park, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | |
| ADDRESS
Cumberland, Maryland | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

05221

CERTIFICATE OF DEATH

533

Allegany

Marshall

Allegany

Marshall

St. John

Marshall

St. John

Marshall

Nov. 26, 1940

Marshall

Allegany

Nov. 26, 1940

Marshall

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Marshall

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05248
Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | c. LENGTH OF STAY IN 1b
<u>90</u> years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | d. STREET ADDRESS
<u>447 Columbia St.</u> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>FRANCIS E. LEWIS</u> | | 4. DATE OF DEATH Month Day Year
<u>May 12 19 60</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 29, 1864</u> |
| 9. AGE (In years last birthday)
<u>95</u> yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Railroad</u> | 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Charles Lewis</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Annie Kline</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> <u>Spanish-American</u> <u>None</u> | |
| 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT Address
<u>Mrs. James Guthridge Cumberland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>490x</u>
(c) <u>490x</u>
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Fractured pelvis; contusion of brain</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Fell out of wheelchair</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>12:55</u> p. m. <u>May 10, 1960</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Infirmery</u> |
| 20f. (City or town)
<u>Cumberland</u> | | (County)
<u>Allegany</u> | (State)
<u>Maryland</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
<u>May 12, 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>May 15, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hill Crest Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Kight</u> | | ADDRESS
<u>Cumberland, Md.</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>MAY 16 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Evans</u> | |

2023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5239

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG263 5-20-60 et

05243

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Xx Cumberland | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First BOUCE Middle HOFFMAN Last LLEWELLYN | | 4. DATE OF DEATH
MAY Month 12 Day 19 Year 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 13, 1884 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. FUNDING YEAR
Months Days Hours Min. | 11. CITIZEN OF WHAT COUNTRY?
USA |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Farm | |
| 11. BIRTHPLACE (State or foreign country)
Black Oak Bottom, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Phillip Bruce Llewellyn | | 14. MOTHER'S MAIDEN NAME
Margaret Price | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Phillip Llewellyn | | 18. ADDRESS
Rt. 3, Keyser, West Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
420.1 DUE TO CORONARY SCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
SUDDEN
--- | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED May 12, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
May 14, 1960 | 22c. NAME OF CEMETERY OR CREMATORY
Bier Cemetery | 22d. LOCATION (City, town, or county) (State)
Rawlings, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
MAY 17 '60 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

ARIZONA STATE DEPARTMENT OF HEALTH—BIRMINGHAM

CERTIFICATE OF DEATH

05244
Reg. Dist. No.

5240

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
X CORRIGANSVILLE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ALBERT Middle W. Last MATTHEWS | | 4. DATE OF DEATH
Month MAY Day 2 Year 1960 | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 11, 1896 | 9. AGE (In years lost birthday)
64 yrs. | IF UNDER 1 YEAR
Months 64 Days 0 Hours 0 Min. | IF UNDER 24 HRS.
Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Celanese Employee | | 10b. KIND OF BUSINESS OR INDUSTRY
Baking | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM E. MATTHEWS | | | | 14. MOTHER'S MAIDEN NAME
ANNA LOWERY MATTHEWS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
220-16-2604 | | INFORMANT
PT'S CHART | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Hemorrhage
DUE TO
162-1
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.
(b) Bronchogenic Carcinoma
DUE TO
(c) 10 mos | | | | | | INTERVAL BETWEEN ONSET AND DEATH
16 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 59 , to May , 19 60 , that I last saw the deceased alive on 2 May , 19 60 , and that death occurred at 9:05 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 441 N. Centre St DATE SIGNED 5/3/60 | | | | | | | |
| ACTUAL SIGNATURE William R. James | | M.D. 441 N. Centre St | | | | | |
| PHYSICIAN'S NAME (Type) W.P. JAMES | | Cumberland, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 6, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Theresa Segler | | | | ADDRESS
Hyndman, Pa. | | 24a. REC'D BY REGISTRAR
MAY 5 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Harris | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Time of death: _____
8. Cause of death: _____
9. Place of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G262 5/6/60 iwk
 8 &

CERTIFICATE OF DEATH

5241

05245
 Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
1 week | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | | | d. STREET ADDRESS
406 MARYLAND AVE. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ADA Middle A. Last MCINTOSH | | | | 4. DATE OF DEATH
Month MAY Day 1st Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 18, 1913 | |
| 9. AGE (In years last birthday)
47 yrs. | | 10. IF UNDER 1 YEAR
Months 11 Days 23 Hours 73 Min. | | 11. AGE (In years last birthday)
11/23 yrs. | | 12. IF UNDER 24 HRS.
Months 11 Days 23 Hours 73 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
W. VA. Terre Alta | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Charles L. Hewitt | | | | 14. MOTHER'S MAIDEN NAME
Emma Fraley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | | | 16. SOCIAL SECURITY NO.
220-28-9683 | | | |
| 17. INFORMANT
PTS. CHART | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interossebotic Cardio-Vascular Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) chronic myocarditis
(c) Thaemia | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 yrs
5 yrs
3 wks | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from June , 19 58 , to May 1 , 19 60 , that I last saw the deceased alive on May 1 , 19 60 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED
Clay B. Durrett M.D. 236 Va. Ave. Cumberland ST. 160 | | | | | | | |
| ACTUAL SIGNATURE DR. C.E. DURRETT. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | |
| 22b. DATE THEREOF
May 4, 1960 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | | | | | | |
| 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | | | | |
| ADDRESS | | | | | | | |
| 24a. REC'D BY REGISTRAR
DATE MAY 4 '60 | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | | | | | |

10101



1237

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **05246**
 Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
15 yrs. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
159 Polk Street | | | | d. STREET ADDRESS
159 Polk Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Louis Middle McKenzie, Sr Last McKenzie, Sr | | | | 4. DATE OF DEATH
Month May Day 4th Year 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 6th, 1887 | |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months 72 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret.-Elec.Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Kelly Springfield | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Jeramiah McKenzie | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
214-07-09 | | 17. INFORMANT
James A. McKenzie, Mt. Savage, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary Sclerosis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 5, 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-7-60 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Patrick's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Mt. Savage, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>J. P. Durrant</i> | | | | ADDRESS
Frostburg, Md. | | 24a. REC'D BY REGISTRAR
DATE MAY 9 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05247
Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | c. LENGTH OF STAY IN 1b
LIFE | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
22 FROSTBURG | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
68 MECHANIC STREET | | d. STREET ADDRESS
68 MECHANIC STREET | |
| 3. NAME OF DECEASED (Type or print)
First MARGARET Middle E. Last McKENZIE | | 4. DATE OF DEATH
Month MAY Day 2 Year 19 60 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 3, 1899 |
| 9. AGE (In years last birthday)
60 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARMON WINNER | | 14. MOTHER'S MAIDEN NAME
IDA HANSEL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
NONE | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
GORA McKENZIE, | | Address
FROSTBURG, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fracture Both Bones Left Leg
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
8 Days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell Down Flight of steps at her Home | |
| 20c. TIME OF INJURY
Month, Day, Year
5:00 a.m. Apr 26 60 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Her Home | | 20f. (City or town) (County) (State)
Frostburg Allegany Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
W O McLane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
W. O. McLANE, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
MAY 5, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
ST. ANN'S CEMETERY | | 22d. LOCATION (City, town, or county) (State)
AVILTON, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Dunst | | ADDRESS
FROSTBURG, MD. | |
| 24a. REC'D BY REGISTRAR
DATE MAY 6 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneass | |

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5248

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05248

| | | | | | | | |
|--|---|---|---------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b <u>4 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>
/d. STREET ADDRESS <u>30 Taylor Street</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Rosina</u> Middle <u>R.</u> Last <u>Maley</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>11</u> Year <u>1960</u> | | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-10-1891</u> | 9. AGE (In years lost birthday)
<u>68</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own housework</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Antonio Ruffo (D)</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rosaria Ruffo.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Daughter- Virginian & Pt.'s chart.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4433X</u> DUE TO <u>uremia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension CK, Diabetes & hyperkalemia</u>
(c) <u>& subarachnoid bleed.</u>
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> 19 <u> </u> , to <u> </u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u>6:10 PM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>B.M. Schindler M.D.</u> | | 22b. DATE
<u>5-14-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Michael's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Frostburg, Md.</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>B.M. Schindler, M.D.</u> | | 22d. ADDRESS
<u>13 Green St., Cumberland, Md.</u> | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22f. DATE SIGNED
<u> </u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5-14-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Michael's Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Frostburg, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>J.P. Dwyer</u> | | | | ADDRESS
<u>Frostburg, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 16 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10038

CERTIFICATE OF BIRTH

10038



5244

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05249

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>19 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>118 Oak St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>VIOLA</u> Middle <u>S</u> Last <u>MILLER</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>7</u> Year <u>1960</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 11, 1883</u> | | 9. AGE (In years last birthday)
<u>76</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Flintstone, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Benjamin Barkman</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Herbst</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
Address
<u>Mrs. John Daychak, Cumberland Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>
<u>443X</u> DUE TO (Acute Failure)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic XXXXX C V Disease</u>
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Fracture of Left Hip</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Fell at Home</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>1:00</u> Hour <u>4:00</u> P. M. <u>April 18, 60</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State)
<u>Cumberland, Alleg. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 7, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 10, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli, Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Frank</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST VIRGINIA MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF DEATH | | 5. TIME OF DEATH | |
| 6. PLACE OF DEATH | | 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | | 10. SIGNATURE OF EXAMINER | |
| 11. SIGNATURE OF WITNESS | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF CLERK | | 14. SIGNATURE OF JURY | | 15. SIGNATURE OF JUDGE | |
| 16. SIGNATURE OF CORONER | | 17. SIGNATURE OF SHERIFF | | 18. SIGNATURE OF TOWNSHIP CLERK | | 19. SIGNATURE OF COUNTY CLERK | | 20. SIGNATURE OF STATE CLERK | |
| 21. SIGNATURE OF VICE PRESIDENT | | 22. SIGNATURE OF SECRETARY | | 23. SIGNATURE OF TREASURER | | 24. SIGNATURE OF COMPTROLLER | | 25. SIGNATURE OF ATTORNEY GENERAL | |
| 26. SIGNATURE OF JUDGE OF SUPERIOR COURT | | 27. SIGNATURE OF JUDGE OF DISTRICT COURT | | 28. SIGNATURE OF JUDGE OF COMMON PLEAS COURT | | 29. SIGNATURE OF JUDGE OF PROBATE COURT | | 30. SIGNATURE OF JUDGE OF MORTUARY COURT | |
| 31. SIGNATURE OF JUDGE OF ORPHANS COURT | | 32. SIGNATURE OF JUDGE OF WARDEN COURT | | 33. SIGNATURE OF JUDGE OF CHANCERY COURT | | 34. SIGNATURE OF JUDGE OF EQUITABLE COURT | | 35. SIGNATURE OF JUDGE OF RECORDS COURT | |
| 36. SIGNATURE OF JUDGE OF DEEDS COURT | | 37. SIGNATURE OF JUDGE OF TAX COURT | | 38. SIGNATURE OF JUDGE OF LAND COURT | | 39. SIGNATURE OF JUDGE OF WATER COURT | | 40. SIGNATURE OF JUDGE OF MINES COURT | |
| 41. SIGNATURE OF JUDGE OF SALT COURT | | 42. SIGNATURE OF JUDGE OF FISH COURT | | 43. SIGNATURE OF JUDGE OF GAME COURT | | 44. SIGNATURE OF JUDGE OF FOREST COURT | | 45. SIGNATURE OF JUDGE OF HUNTING COURT | |
| 46. SIGNATURE OF JUDGE OF FISHING COURT | | 47. SIGNATURE OF JUDGE OF HUNTING COURT | | 48. SIGNATURE OF JUDGE OF FOREST COURT | | 49. SIGNATURE OF JUDGE OF MINES COURT | | 50. SIGNATURE OF JUDGE OF SALT COURT | |
| 51. SIGNATURE OF JUDGE OF FISH COURT | | 52. SIGNATURE OF JUDGE OF GAME COURT | | 53. SIGNATURE OF JUDGE OF FOREST COURT | | 54. SIGNATURE OF JUDGE OF MINES COURT | | 55. SIGNATURE OF JUDGE OF SALT COURT | |
| 56. SIGNATURE OF JUDGE OF FISHING COURT | | 57. SIGNATURE OF JUDGE OF HUNTING COURT | | 58. SIGNATURE OF JUDGE OF FOREST COURT | | 59. SIGNATURE OF JUDGE OF MINES COURT | | 60. SIGNATURE OF JUDGE OF SALT COURT | |
| 61. SIGNATURE OF JUDGE OF FISH COURT | | 62. SIGNATURE OF JUDGE OF GAME COURT | | 63. SIGNATURE OF JUDGE OF FOREST COURT | | 64. SIGNATURE OF JUDGE OF MINES COURT | | 65. SIGNATURE OF JUDGE OF SALT COURT | |
| 66. SIGNATURE OF JUDGE OF FISHING COURT | | 67. SIGNATURE OF JUDGE OF HUNTING COURT | | 68. SIGNATURE OF JUDGE OF FOREST COURT | | 69. SIGNATURE OF JUDGE OF MINES COURT | | 70. SIGNATURE OF JUDGE OF SALT COURT | |
| 71. SIGNATURE OF JUDGE OF FISH COURT | | 72. SIGNATURE OF JUDGE OF GAME COURT | | 73. SIGNATURE OF JUDGE OF FOREST COURT | | 74. SIGNATURE OF JUDGE OF MINES COURT | | 75. SIGNATURE OF JUDGE OF SALT COURT | |
| 76. SIGNATURE OF JUDGE OF FISHING COURT | | 77. SIGNATURE OF JUDGE OF HUNTING COURT | | 78. SIGNATURE OF JUDGE OF FOREST COURT | | 79. SIGNATURE OF JUDGE OF MINES COURT | | 80. SIGNATURE OF JUDGE OF SALT COURT | |
| 81. SIGNATURE OF JUDGE OF FISH COURT | | 82. SIGNATURE OF JUDGE OF GAME COURT | | 83. SIGNATURE OF JUDGE OF FOREST COURT | | 84. SIGNATURE OF JUDGE OF MINES COURT | | 85. SIGNATURE OF JUDGE OF SALT COURT | |
| 86. SIGNATURE OF JUDGE OF FISHING COURT | | 87. SIGNATURE OF JUDGE OF HUNTING COURT | | 88. SIGNATURE OF JUDGE OF FOREST COURT | | 89. SIGNATURE OF JUDGE OF MINES COURT | | 90. SIGNATURE OF JUDGE OF SALT COURT | |
| 91. SIGNATURE OF JUDGE OF FISH COURT | | 92. SIGNATURE OF JUDGE OF GAME COURT | | 93. SIGNATURE OF JUDGE OF FOREST COURT | | 94. SIGNATURE OF JUDGE OF MINES COURT | | 95. SIGNATURE OF JUDGE OF SALT COURT | |
| 96. SIGNATURE OF JUDGE OF FISHING COURT | | 97. SIGNATURE OF JUDGE OF HUNTING COURT | | 98. SIGNATURE OF JUDGE OF FOREST COURT | | 99. SIGNATURE OF JUDGE OF MINES COURT | | 100. SIGNATURE OF JUDGE OF SALT COURT | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5245

Item 8 Film 9264 6-20-60 et

CERTIFICATE OF DEATH

05250

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
221 AVIRETT AVE. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle A. Last MORGAN | | 4. DATE OF DEATH
Month MAY Day 27 Year 1960 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept 25, 1884 |
| 9. AGE (In years last birthday)
75 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O Railroad | |
| 10c. PLACE OF BIRTH (State or foreign country)
Scotland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES MORGAN | | 14. MOTHER'S MAIDEN NAME
ELLEN TEMBELTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Robert Morgan | | Address
221 Avirett Ave. Cumb. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, generalized
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Prostate
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
6 mos
10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 27, 1960 to May 27, 1960 , that (I) (we) last saw the deceased alive on May 27, 1960 and that death occurred at 6:30 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. S.G. Weisman | | 22b. DATE SIGNED
5/30/60 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. S.G. WEISMAN | | 22d. ADDRESS
59 Green St Cumberland, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 31, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
SS Peter & Paul's | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | 25a. REC'D BY REGISTRAR
JUN 1 '60 | |
| ADDRESS
Cumberland, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles L. George | |

CERTIFICATE OF DEATH

1924

ALLIANCE

INDUSTRIAL

DISCOUNT

DISCOUNT

201 AVENUE AVE.

201 AVENUE AVE.

M. L. L.

M. L. L.

M. L. L.

M. L. L.

JAMES H. H.

JAMES H. H.

James H. H. was born on the 1st day of January, 1870, at the residence of his parents, James H. H. and Mary H. H., in the town of ...

James H. H. was educated in the common schools of his native town, and attended the ...

James H. H. was employed as a ...

1924

1924

1924

1924

1924

1924

1924

DR. E. E. HENRY

DR. E. E. HENRY

DR. E. E. HENRY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5246

CERTIFICATE OF DEATH

06428

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MARYLAND | | c. LENGTH OF STAY IN 1b
11 DAYS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
KIFER, MARYLAND | | d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL & WARWICK AVES. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
ALICE
Middle
ADELE
Last
MUELLER | | 4. DATE OF DEATH
Month
MAY
Day
31
Year
1960 | | 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1923
SEPT. 25, 1924 | | 9. AGE (In years and birthday)
36 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SECRETARY | | 10b. KIND OF BUSINESS OR INDUSTRY
INSURANCE | | 11. BIRTHPLACE (State or foreign country)
PAW PAW, W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
WALTER E. MUELLER | | 14. MOTHER'S MAIDEN NAME
OLIVE SHUMAKER | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
416X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
Chronic Rheumatic heart disease
Sometime prior to 1953 | | INTERVAL BETWEEN ONSET AND DEATH
Sometime prior to 1953 | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9.5.1953 to 5-31-60 , that (I) (we) last saw the deceased alive on 5.31.1960 and that death occurred at 5:40 P.M. the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
W. F. Williams | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
6-1-60 | | 22c. PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | | 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
6/3/1960 | | 23c. NAME OF CEMETERY OR CREMATORY
SULPHUR SPRINGS CEM. | | 23d. LOCATION (City, town, or county) (State)
KIFER, ALLEGANY MD. | | 24. FUNERAL DIRECTOR'S SIGNATURE
PAKKS FUNERAL HOME | | ADDRESS
BERKELEY SPRINGS, W. VA. | | 25a. REC'D BY REGISTRAR
JUN 8 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | 25c. DATE
JUN 8 '60 | | 25d. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | 25e. DATE
JUN 8 '60 | | 25f. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | 25g. DATE
JUN 8 '60 | | 25h. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

Cap
Act

CERTIFICATE OF DEATH

7245

DATE

DECEASED, NAME

11 DAYS

WATER, NAME

DECEASED, SEX

DATE

AGE

SEX

PLACE

DATE

TIME

WALTER E. HARTLEY

DATE

DECEASED, NAME

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5283

CERTIFICATE OF DEATH

05251

| | | | |
|---|-------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b X Nikep | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS 1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle L. Last MUIR | | 4. DATE OF DEATH 5/13/1960
Month 5 Day 13 Year 19 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/27/1894 |
| 9. AGE (In years lost birthday) 66 yrs. | | IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Shaft, MD. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Michael Muir | | 14. MOTHER'S MAIDEN NAME Janet Telford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 220-10-2302 | |
| 17. INFORMANT Mrs. Charles Muir, | | Address Nikep, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 4 days
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma; Emphysema; Congestive heart failure | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o. m. 19 p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 1956 to May 13, 1960 that (I) (we) last saw the deceased alive on May 13, 1960 , and that death occurred at 9 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE L.R. Miles, Jr. | | 22b. DATE SIGNED 5-14-60 | |
| 22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., MD | | 22d. ADDRESS LONACONING MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/16/1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | | 23d. LOCATION (City, town, or county) (State) Moscow, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN | | ADDRESS LONACONING, MD. | |
| 25a. REC'D BY REGISTRAR MAY 17 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraw | |

CERTIFICATE OF DEATH

1933

1933

Albany

Henry and

Albany

Wickup

Providence

Providence Hospital

Providence

Wickup

Providence

White

Wickup

U.S.A.

Wickup, Mo.

Residence

James W. Wickup

Providence

Wickup, Mo.

Charles W. Wickup

(Wickup)

1933-1934

1933

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MAYAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
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5247

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05252

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write
RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN 1b
2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVENUES. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
d. STREET ADDRESS
740 MARYLAND AVENUE
e. IS RESIDENCE
ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF
DECEASED
(Type or print)
First Middle Last
MAUDE THEODOR DORSIA NOLAN | | 4. DATE
OF
DEATH
Month Day Year
MAY 31 1960 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 2, 1887 |
| 9. AGE (In years
lost birthday)
73 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Clearsprings, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Wm Hiram H. WHITE | | 14. MOTHER'S MAIDEN NAME
MARY ELLEN HULL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Hypertensive Cardiac
443X DUE TO
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost. (b) Vascular Disease
DUE TO (c) 4417 years. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-14-1960 to 5-31-1960 that (I) (we) last
saw the deceased alive on 5-30-1960 and that death occurred at 2:25 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. F. Williams
M.D. | | 22b. DATE
SIGNED
5-31-60 | |
| 22c. PHYSICIAN'S
NAME (Type)
DR. W. F. WILLIAMS | | 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 2, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 6 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

1955

CERTIFICATE OF DEATH

1955

ALLICAM

WYLLID

ALLICAM

WYLLID

2 DAYS

WYLLID

300 MYRTLE AVENUE

GENERAL HOSPITAL
1000 E. BROADWAY

WYLLID

WYLLID

APRIL 2, 1955

WYLLID

WYLLID

WYLLID

GENERAL HOSPITAL - WYLLID, WYLLID

WYLLID

6:25 AM

155 S. CENTRE ST., WYLLID, WYLLID

WYLLID

WYLLID

WYLLID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5284

CERTIFICATE OF DEATH

05253

| | | | | | | | | |
|---|------------------------------------|--|--|--|--|---|--------------------|-------------------|
| 1. PLACE OF DEATH
a. COUNTY
Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg
c. LENGTH OF STAY IN 1b
1 Week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miner's Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
22 Frostburg,
d. STREET ADDRESS
136 W. Mechanic St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First
Evelyn
Middle
Summers
Last
Perkins | | 4. DATE OF DEATH
Month
May
Day
10th
Year
19 60 | | | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 15th, 1911 | 9. AGE (In years lost birthday)
49 yrs. | IF UNDER 1 YEAR
Months
49 | IF UNDER 24 HRS.
Days
49 | Hours
49 | Min.
49 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own housework | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
William Summers | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
James A. Perkins, 136 W. Mechanic St. Md.
Address
F'bg. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic glomerulonephritis
592x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Right Heart Failure
DUE TO
(c) Chronic Right Heart Failure
INTERVAL BETWEEN ONSET AND DEATH
8 mos. 22?
3 mos. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 1957 to 5-10-1959 , that (I) (we) last saw the deceased alive on 5/10-1960 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
Martin M. Rothstein M.D. | | 22b. DATE SIGNED
5/11/60 | | 22c. PHYSICIAN'S NAME (Type)
Martin M. Rothstein | | | | |
| 22d. ADDRESS
48 Broadway, Frostburg, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-13-60 | | 23c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | | 23d. LOCATION (City, town, or county) (State)
Frostburg, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durrant | | ADDRESS
Frostburg, Md. | | 25a. REC'D BY REGISTRAR
DATE
MAY 16 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | |

15381

CERTIFICATE OF DEATH

2521



State of New York
County of Albany
City of Albany
I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of Albany, do hereby certify that on the 15th day of January, 1911, at Albany, New York, died _____, of the County of Albany, State of New York, who was born on the _____ day of _____, 18____, at _____, _____, New York, and who was _____ years of age at the time of death. The cause of death was _____, and the manner of death was _____.

Witness my hand and the seal of the City and County of Albany, this _____ day of _____, 1911.

Medical Officer of Health
Attest:

City Clerk

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5285

CERTIFICATE OF DEATH

05254

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle T. Last PHILLIPS | | | | 4. DATE OF DEATH Month May Day 1st. Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/8/1883 | |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Lonacoing, MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Phillips | | | | 14. MOTHER'S MAIDEN NAME Isabelle Ternent | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-05-5832 | | 17. INFORMANT Address Mrs. Mary Phillips, Lonacoing, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency 24 hr.
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary sclerosis. DUE TO
(c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. Congestive Failure | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 20, 1960 to May 1, 1960 , that the last saw the deceased alive on May 1, 1960 , and that death occurred at 5:50 A M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Alvin J. Walters. M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/2/60. | |
| 22c. PHYSICIAN'S NAME (Type) Alvin J. Walters. | | | | 22d. ADDRESS 48 Broadway, Frostburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/4/1960 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park. | | 23d. LOCATION (City, town, or county) (State) Cumberland, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GEORGE EICHORN LONACONING, MD. | | | | 25a. REC'D BY REGISTRAR DATE MAY 4 '60 | | 25b. REGISTRAR'S SIGNATURE Charles L. Kraus | |

MEDICAL CERTIFICATION

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STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

1900

Albany

Albany

Albany

Albany

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Albany

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Albany

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|------------------|---|--|-------------------------|---|---------------------------------|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | |
| 5248 | | | | | 05255 | | | | |
| 1. PLACE OF DEATH
a. COUNTY | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE | | | | |
| ALLEGANY MARYLAND | | | | | WEST VIRGINIA ALLEGANY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | |
| CUMBERLAND | | | | 9 days | X RURAL RAILINGS, MD. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| SACRED HEART HOSPITAL | | | | | Route 3, Keyser, West Virginia | | | | |
| 3. NAME OF DECEASED
(Type or print) | | | First Middle Last | | 4. DATE OF DEATH | | Month Day Year | | |
| LILLIAN M PSIMER | | | | | 5/11/60 | | 19 60 | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| FEMALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5/11/60 6/15/12 | | 47 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | Own Home | | W.VA. Mineral County | | | USA | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Bouce Llewellyn | | | | | LuLu May Demmison | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| no | | | | | CHART | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 585X pulmonary embolism
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cholecystectomy on 5-9-60
DUE TO (c) cholecystitis and cholelithiasis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1/2 hour
2 1/2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 19 | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-3-1960 to 5-11-1960 that (I) (we) last saw the deceased alive on 5-11-1960, and that death occurred 5-11-1960 from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | 22b. DATE SIGNED | | | | |
| L. Briggs | | | | | 5/13/60 | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| DR. L. BRIGGS | | | | | 57 GREENE STREET | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | |
| Burial | | | 5/14/60 | | Rest Lawn Memorial Park | | Cumberland, Maryland | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John J. Hafer, Cumberland, Maryland | | | | | MAY 17 '60 | | Arthur L. Hafer | | |

100-250

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
FEDERAL BUREAU OF INVESTIGATION
DIVISION OF IDENTIFICATION
WASHINGTON, D. C. 20540

100-250

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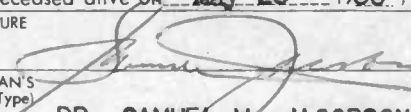
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VR A15 (4)
15M 9/59

5249

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05256

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY GRANT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MOOREFIELD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
WARWICK & MEMORIAL AVENUES | | d. STREET ADDRESS
85X-3 | |
| 3. NAME OF DECEASED (Type or print)
First CALVIN Middle J. Last RAINES | | 4. DATE OF DEATH
Month MAY Day 27 Year 1960 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCTOBER 14, |
| 9. AGE (In years lost birthday)
86 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
GEORGE RAINES | | 14. MOTHER'S MAIDEN NAME
CATHERINE POWERS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
465X IMMEDIATE CAUSE (a) Acute left ventricular failure.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary embolus
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Prostatic surgery for hypertrophic prostatitis and bladder retention. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
sudden
sudden | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/11/60 19____, to 5/27/60 19____, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on May 26 19 60 , and that death occurred at 7:55 AM the causes and on the date stated above. | | | |
| 22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)
DR. SAMUEL M. JACOBSON | | 22b. DATE SIGNED
May 28, 1960
22d. ADDRESS
50 PERSHING ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-29-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hout Cemetery | | 23d. LOCATION (City, town, or county) (State)
6 mile N. Moorefield, Hardy Co. W. Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Earl B Thrush | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | |

411-212-123

Y. H. H. 10

CYD 3

2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

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5250 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

05257

| | | | | | | | |
|---|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>1002 Holland St.</u> | | | | d. STREET ADDRESS
<u>1002 Holland St.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>DAVID</u> Middle <u>RANSOM</u> Last <u>RANSOM</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>8</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 17, 1949</u> | | 9. AGE (In years last birthday)
<u>11</u> yrs. | IF UNDER 1 YEAR
Months <u>11</u> Days <u>19</u> | IF UNDER 24 HRS.
Hours <u>11</u> Min. <u>19</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Leland B. Ransom</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mildred McMillen</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Dr. Leland Ransom, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>351 X</u> IMMEDIATE CAUSE (a) <u>Asphyxiation (asphyxiation) -</u>
DUE TO <u>Cerebral Palsy</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.
(b) <u>Cerebral Palsy</u>
DUE TO <u>Cerebral Palsy</u>
(c) <u>Cerebral Palsy</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 min.</u>
<u>11 yrs -</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan - 1958</u> to <u>May - 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>March 19, 60</u> , and that death occurred at <u>3P</u> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Harold Wm Eliason</u> M.D. | | | | 22b. DATE SIGNED
<u>May 11 '60</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>HAROLD Wm ELIASON</u> | |
| 22d. ADDRESS
<u>126 HUNTER ST CUMBERLAND MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>May 11, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Sunset Memorial Park</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Kight</u> | | | | ADDRESS
<u>Cumberland, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 11 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hanna</u> | | | |

1587

CERTIFICATE OF DEATH

2520

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF VITAL RECORDS

CHILDREN

SECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5251

05258

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
27 DAYS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WESTERNPORT | | d. STREET ADDRESS
237 WOOD STREET, EXT. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
SAMUEL | | First
L. | | Middle
ROSS | | Last
ROSS | | 4. DATE OF DEATH
Month
MAY | | Day
24 | | Year
19 60 | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
AUGUST 9, 1887 | | 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Coal mine | | 11. BIRTHPLACE (State or foreign country)
ITALY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
VINCENT ROSS | | 14. MOTHER'S MAIDEN NAME
JENNIE - | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
215-10-843 | | 17. INFORMANT
MEMORIAL HOSPITAL - | | Address
CUMBERLAND, MD. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) 1. Arteriosclerotic Cardiovascular
DUE TO 490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 2. Lobes Pneumonia
DUE TO
(c) 3. Silicosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Westernport | | (County)
Wf | | (State)
MD | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-2-1960 to 5-24-1960 that (I) (we) last saw the deceased alive on 5-23-1960 and that death occurred at 4:30 AM from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
Dr. W. F. Williams | | 22c. PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | | 22d. ADDRESS
122 SOUTH CENTRE STREET, CUMBERLAND, MD. | | 22b. DATE SIGNED | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/27/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos | | 23d. LOCATION (City, town, or county)
Westernport Wf | | (State)
MD | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ed Boal - Westernport Md | | ADDRESS
Ed Boal - Westernport Md | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | | | | | |

CERTIFICATE OF DEATH

1921

RESIDENCE

DECEASED

ALLEGED

PORTLAND

ST. PAUL

CITY OF

ST. JOHN STREET, BOSTON

ST. JOHN STREET, BOSTON

ST. JOHN STREET, BOSTON

1902

1902

AUGUST 1, 1902

WHITE

MALE

ITALY

ST. JOHN STREET, BOSTON

ST. JOHN STREET, BOSTON

JOHN

JOHN

ST. JOHN STREET, BOSTON

ST. JOHN STREET, BOSTON

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ST. JOHN STREET, BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 5252 | | | | | 5252 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b
18 DAYS | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND
d. STREET ADDRESS
208 MARYLAND AVE.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ROBERT WAYNE ROUGH, JR. | | | | | 4. DATE OF DEATH
Month Day Year
MAY 12 19 60 | | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JAN. 3, 1960 | | 9. AGE (In years last birthday)
yrs. 4 | | IF UNDER 1 YEAR
Months Days
4 9 | | IF UNDER 24 HRS.
Hours Min.
9 15 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Memorial Hospital | | | | 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
ROBERT WAYNE ROUGH, SR. | | | | | | 14. MOTHER'S MAIDEN NAME
JANICE BROWN | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock, probably nervous in origin
DUE TO 570.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post-operative adhesions of the
DUE TO intestine. (c) (operated on for intestinal obstruction)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) one hour
INTERVAL BETWEEN ONSET AND DEATH one hour | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 14, 1960 to May 12, 1960 , that (I) (we) last saw the deceased alive on May 12, 1960 , and that death occurred at 8:25 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
A. J. Hashim | | | | 22b. DATE SIGNED
5/13/60 | | | | 22c. PHYSICIAN'S NAME (Type)
DR. HASHIM | | | | | | | |
| 22d. ADDRESS
20 GREENE ST., CUMBERLAND, MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
5/15/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Temple Cemetery | | 23d. LOCATION (City, town, or county) (State)
Near Wellersburg, Pa. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | | | 25a. REC'D BY REGISTRAR
MAY 19 '60 | | 25b. REGISTRAR'S SIGNATURE
Charles E. Kline | | | | | | | |

2038171XV4

15253

1-1 CERTIFICATE OF BIRTH

2282

ALLEGANY

WYOMING

ALLEGANY

WYOMING

15 DAYS

15 DAYS

2nd WYOMING AVE.

2nd WYOMING AVE.

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WHITE BROWN

WHITE BROWN

WHITE BROWN

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DR. HARRIS

DR. HARRIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

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060

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5253

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05260

| | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE W. VA. b. COUNTY MINERAL | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | | | c. LENGTH OF STAY IN 1b
16 HRS. 17 MINS. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WILEY FORD, W. VA. | | | | | |
| d. NAME OF HOSPITAL (If not at home, give street address)
MEMORIAL HOSPITAL & WARWICK AVE. | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First BABY BOY Middle SACHS Last SACHS | | | | 4. DATE OF DEATH
Month MAY Day 14 Year 1960 | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 13, 1960 | | 9. AGE (In years lost birthday) yrs.
16 | | IF UNDER 1 YEAR
Months 16 Days 17 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MD. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARVEY DENVER SACHS | | | | 14. MOTHER'S MAIDEN NAME
MARION TAYLOR | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
761.5 DUE TO Prematurity
Placenta Praevia - Complete
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 13, 1960 to May 14, 1960 , that (I) (we) last saw the deceased alive on May 14, 1960 and that death occurred at 2:07 P.M. on the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
W. Royce Hodges | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. HODGES & MOULD | | | | 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
5-16-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | | | ADDRESS
Cumberland, Md | | | | 25a. REC'D BY REGISTRAR
DATE MAY 19 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | | | |

Ms 460 2060343XV1

(M)

ALLEGANY

V. VA.

MINERAL

10 REG. 13 HIND, GILLY FORD, V. VA.

CUMBERLAND, MD.

REMOVAL & PARADISE AVE.

24TH

DAY 501

MAY

13 MAY 1940

WHITE

MALE

WALTER TAYLOR

REAR, BENTON CIRCLE

MINERAL HOSPITAL, CUMBERLAND, MD.

ISS. C. CENTRE ST., CUMBERLAND, MD.

DR. HODGES & NOVA

MD 13 10

REMOVAL & PARADISE AVE.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5254

CERTIFICATE OF DEATH

05261

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | | c. LENGTH OF STAY IN 1b
24 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | | | |
| d. NAME OF HOSPITAL, OR INSTITUTION (If none, give street address)
MEMORIAL & WARWICK AVE. | | | | d. STREET ADDRESS
18 ELDER STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CATHERINE Middle D. Last SHARON | | | | 4. DATE OF DEATH
Month MAY Day 12 Year 19 60 | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-18-1915 | | | |
| 9. AGE (In years last birthday) yrs. 45 | | IF UNDER 1 YEAR
Months 0 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Previous-Textile | | 11. BIRTHPLACE (State or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
JOSEPH BEARINGER | | | | 14. MOTHER'S MAIDEN NAME
MYRTLE DORBIN | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
217-10-710 | | 17. INFORMANT Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
416X IMMEDIATE CAUSE (a) Rheumatic C.V.D. - Cerebral Emboli
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Alleg Md | | 20f. City or town (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/6/60 19 _____ to 5/12/60 19 _____ that (I) (we) last saw the deceased alive on 4/6/60 19 _____ and that death occurred at 9:20 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
DR. R.J. WILLIAMS | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. R.J. WILLIAMS | | | | 22d. ADDRESS
122 SOUTH CENTRE ST., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-15-60 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's cem. | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | | | ADDRESS
Cumberland, Md | | 25a. REC'D BY REGISTRAR
MAY 19 '60 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | | | |

MEDICAL CERTIFICATION

(M)

(I)

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0323

CERTIFICATE OF DEATH

0323



ALLIANCE

WILLIAM

WILLIAM

ST. LOUIS, MO.

1911

ST. LOUIS, MO.

1123 WEST STREET

ST. LOUIS, MO.

1911

1911

1911

1911

1911

U.S.A.

U.S.A.

WILLIAM

WILLIAM

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05262
Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
25 min. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Emma Middle May Last Shipley | | | | 4. DATE OF DEATH
Month May Day 23 Year 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 29, 1883 | |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
James K. Hickie | | | | 14. MOTHER'S MAIDEN NAME
Susan Barnes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address Daughter, Mrs. Beatrice Johnstone, Rt. #1, Cumberland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO (b) Coronary Sclerosis
DUE TO (c) Coronary Sclerosis | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarolic M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarolic MD. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 5/23/60 | | | |
| 22a. BURIAL, CREMATION, REMAINS (Specify)
Burial | | 22b. DATE THEREOF
5/26/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Lee Silcox
ADDRESS Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
DATE MAY 27 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kears | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be far, send to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05263

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Route 51</u> | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>22 miles east of Cumberland Allegany, Md</u> | | d. STREET ADDRESS
<u>513 Maryland Avenue</u> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First <u>William</u> Middle <u>Dennis</u> Last <u>Shook</u> | 4. DATE OF DEATH
Month <u>May</u> Day <u>3</u> Year <u>19 60</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec 16, 1918</u> |
| 9. AGE (In years last birthday)
<u>41</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>71 cab</u> | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> |
| 12. CITIZEN OF WHAT COUNTRY
<u>U. S. A.</u> | | | |
| 13. FATHER'S NAME
<u>William Shook</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillie May Groves</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>Yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO.
<u>212-12-8762</u> | 17. INFORMANT
<u>Mrs. Martha Shook</u> <u>513 Maryland Avenue, Cumberland, Maryland</u> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Crushed Skull</u>
DUE TO (b) <u>Automobile Accident</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Also fractures and burns of lower extremities</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Auto crashed into tree</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>11:00</u> o. m. <u>5/3</u> 19 <u>60</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>route 51</u> | 20f. (City or town) <u>22 miles east of Cumberland Allegany Md.</u> (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/5/60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Sunset Memorial Park</u> |
| | | 22d. LOCATION (City, town, or county)
<u>Cumberland Maryland</u> | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ruth E. Silcox</u> | | 24a. REC'D BY REGISTRAR
<u>MAY 10 1960</u> | |
| ADDRESS
<u>Cumberland Maryland</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5290

CERTIFICATE OF DEATH

05264

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westernport</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>43 Westernport</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>74 Main</u> | | | d. STREET ADDRESS
<u>74 Main</u> | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Shultice</u> | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>19 60</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Mar. 20, 1871</u> | | 9. AGE (In years last birthday)
<u>89</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>house wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>James Morrison</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Esther R. Clark</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. A.B. Kalbaugh - Westernport, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Left Ventricular Failure</u>
DUE TO
(c) <u>Acute Myocardial Infarction</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>3 days</u>
<u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> <u>19 59</u> to <u>April 4</u> <u>19 60</u> , that (I) (we) last saw the deceased alive on <u>April 3</u> <u>19 60</u> , and that death occurred at <u>8:15 A</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Robert W. Bess, Jr., M. D.</u> | | | | 22b. DATE SIGNED
M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Robert W. Bess, Jr., M. D.</u> | | | | 22d. ADDRESS
<u>Piedmont, W. Va.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5/6/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Philos</u> | |
| | | | | 23d. LOCATION (City, town, or county) (State)
<u>Westernport Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>E. J. Beral</u> | | | ADDRESS
<u>Westernport, Md.</u> | | |
| 25a. REC'D BY REGISTRAR
DATE <u>MAY 6 '60</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Cirilia S. Hauer</u> | | | |

1952

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF VETERINARY MEDICINE
WASHINGTON, D. C. 20540



5256

CERTIFICATE OF DEATH

05265

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
D. O. A. at 02 Cumberland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital | | | | 1/d. STREET ADDRESS
116 S. Lee St. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Alex | | First | | Middle | | Last | |
| 4. DATE OF DEATH
May 25, | | Month | | Day | | Year
19 60 | |
| 5. SEX
M | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 1, 1898 | | 9. AGE (In years last birthday)
62 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Garbage collector | | | | 10b. KIND OF BUSINESS OR INDUSTRY
City of Cumberland | | 11. BIRTHPLACE (State or foreign country)
Portsmouth, Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | | | | |
| 13. FATHER'S NAME
Samuel Simpson | | | | 14. MOTHER'S MAIDEN NAME
Martha ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
215-14-6086 | | INFORMANT
Mrs. Clara Simpson, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
422.1 DUE TO Cerebral Vascular Accident
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.
(b) Subarachnoid arteriosclerosis Cerebrovascular
(c) years | | | | INTERVAL BETWEEN ONSET AND DEATH
hrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 11, 1958 to May 1960 , that I last saw the deceased alive on May 6, 1960 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
G. Overton Himmelwright | | M.D. | | ADDRESS (Street, city or town, state)
133 Virginia Ave Cumberland, Md | | DATE SIGNED
5/26/60 | |
| PHYSICIAN'S NAME (Type)
G. Overton Himmelwright, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 28, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer | | | | ADDRESS
Cumberland, Md | | 24a. REC'D BY REGISTRAR
DATE MAY 31 '60 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
Clara Simpson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5

4

5257

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05266

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
3 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ELIZABETH Middle E. Last SKIPPER | | 4. DATE OF DEATH
Month MAY Day 16 Year 1960 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCTOBER 7, 1899 |
| 9. AGE (In years last birthday)
60 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Six Mile Run, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARTMAN O'NEAL | | 14. MOTHER'S MAIDEN NAME
ESTHER WILLIAMS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CORONARY ARTERY DISEASE
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
4 DAYS
4 TO 5 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-13-60 19 to 5-16-60 19 that (I) (we) last saw the deceased alive on 5-15-60 19 and that death occurred at 2:20 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>William P. James</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
DR. WILLIAM P. JAMES | | 22d. ADDRESS
441 NORTH CENTRE ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-18-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Methodist Cemetery | | 23d. LOCATION (City, town, or county) (State)
Mt. Savage Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Paul H. Montross</i> | | 25a. REC'D BY REGISTRAR
20 '60 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Arthur L. Kline</i> | | | |

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05256

ALLEGANY

MARYLAND

ALLEGANY

MT. SHAVE

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL
MEMORIAL & WARDEN AVE.

SKIPPER

ELIZABETH E.

OCTOBER 7, 1939

FEMALE WHITE

EDGAR WILLIAMS

MARTIN O'NEAL

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

CONGESTIVE HEART FAILURE

CORONARY ARTERY DISEASE

14 DAYS

14 TO 15 YEARS

-10-30

-11-30

-12-30

101 NORTH CENTRE ST., CUMBERLAND, MD.

DR. WILLIAM F. JAMES

1-1-40

1-1-40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5258 CERTIFICATE OF DEATH

05267

| | | | |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 4/29/53 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg | |
| d. STREET ADDRESS 50 Bealle Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Effie Smith | | 4. DATE OF DEATH May 22, 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/9/1869 |
| 9. AGE (In years last birthday) 91 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Gen Clerk - Dept. Store | | 10b. KIND OF BUSINESS OR INDUSTRY Rosenbaum's | |
| 11. BIRTHPLACE (State or foreign country) Frostburg, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Smith | | 14. MOTHER'S MAIDEN NAME Anne Faraday | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT P.O.Box 599 | | Address Cumberland, Md. | |
| Allegany County Infirmary Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Chronic Myocardial Degeneration
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage
DUE TO (c) Cerebral Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
>
>
> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/29/53 19 to 5/22/60 19, that (I) (we) last saw the deceased alive on 5/23/60 19, and that death occurred at 1:50 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James E. McLean | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean | | 22d. ADDRESS 49 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-24-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | | 23d. LOCATION (City, town, or county) (State) Frostburg, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. P. Burst | | 25a. REC'D BY REGISTRAR DATE MAY 25 '60 | |
| ADDRESS Frostburg, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Huns | |

(M)

(1)

Allegany

Underland

W32/52

Marshall

Frederick

Allegany County Jail

50 Reels

Radio

Smith

Ray

White

3/2/52

91

Retired: 1st Clerk - Dept. Store

Frederick, Maryland

John Smith

Anne Parshay

P.O. Box 599

Underland, Md.

Allegany County Jail

2/23/50

W32/52

2/22/50

Dr. James E. Nolan

19 Greene St., Underland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05268

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
8 1/2 HOURS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
WARWICK & MEMORIAL HOSPITAL | | | | 1. d. STREET ADDRESS
843 BRADDOCK ROAD | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ELIZABETH Middle M. Last SMITH | | | | 4. DATE OF DEATH
Month MAY Day 29 Year 19 60. | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 30, 1911 | |
| 9. AGE (In years last birthday)
48 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
HARRY W. MATHENEY | | | | 14. MOTHER'S MAIDEN NAME
GERTRUDE SINCELL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage with left Hemiplegia
DUE TO 331X
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
13 hours | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6 A.M. to 1:57 P.M. 29 May 1960 that (I) (we) last saw the deceased alive on 29 May 1960 , and that death occurred at 1:57 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W. Alfred Van Ormer M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
29 May 60 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. W. ALFRED VAN ORMER | | | | 22d. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 1, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JUN 3 '60 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

bp



WILLIAM

CHURCH

CHURCH & WHITE

ELIZABETH

WHITE

HENRY M. MATTHEW

WILLIAM

CHURCH

CHURCH & WHITE

ELIZABETH

WHITE

WILLIAM

HENRY M. MATTHEW

HENRY M. MATTHEW

Handwritten notes and signatures in the center of the page.

155 2, CENTRAL ST., CHURCH

DR. W. ALFRED VAN COTT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

1
M
5260
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05269

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | c. LENGTH OF STAY IN 1b
53 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | d. STREET ADDRESS
406 LOUISIANA AVE. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First SMITH, Middle KATE Last ELIZABETH | | 4. DATE OF DEATH
Month 5 Day 8 Year 1960 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-31-1877 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
MARTINSBURG, W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
LOUIS WELLEN | | 14. MOTHER'S MAIDEN NAME
MARGARET LOUISE CREIG | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous
DUE TO Carcinoma of Both Breasts
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 170X
(c) 170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
3 years
9 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1956 to May 8, 1960 , that (I) (we) last saw the deceased alive on May 7, 1960 and that death occurred at 7:03 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Clay E. Durrett | | 22b. DATE SIGNED
5/9/60 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. CLAY E. DURRETT | | 22d. ADDRESS
236 W. 1st Cumberland Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/11/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | 25a. REC'D BY REGISTRAR
MAY 16 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Hines | | | |

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RAY, H. DISCUSSION:

2011/12/18

DR. CLAY E. BARNETT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05270
Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
38yrs | | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
21 Pennsylvania Ave. | | | | d. STREET ADDRESS
21 Pennsylvania Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Ellis T. Sneathen | | | | 4. DATE OF DEATH
Month Day Year
May 31, 1960 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 15, 1900 | | 9. AGE (In years last birthday)
59 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Builder | | 11. BIRTHPLACE (State or foreign country)
Fort Ashby W.Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel M. Sneathen | | | | 14. MOTHER'S MAIDEN NAME
Sally Richardson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No. | | 16. SOCIAL SECURITY NO.
214-05-6107 | | 17. INFORMANT Address
Mrs. Hilda Sneathen, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun Shot Wound Of Head
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self Inflicted | | | | | |
| 20c. TIME OF INJURY
Hour g. m. a. m.
5:00 5-31 1960 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Cumberland Allegany Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED May 31, 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 3, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
DATE JUN 3 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | |

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5286 **CERTIFICATE OF DEATH**

05271

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
3 days. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARGARET Middle Last SNYDER | | 4. DATE OF DEATH
Month 5/16/1960 Day Year 19 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/12/1981 |
| 9. AGE (In years last birthday)
79 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Lonaconing, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
David Beeman | | 14. MOTHER'S MAIDEN NAME
Sarah C. McCloud | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Lindley Snyder | | Address
Lonaconing, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
450.0 IMMEDIATE CAUSE (a) myocardial dilatation acute
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH
12 hours |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 1956 to May 16, 1960 , that (I) (we) last saw the deceased alive on May 16 1960 , and that death occurred at 6 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
George Eichhorn | | 22b. ADDRESS
LONACONING MD. | |
| 22c. PHYSICIAN'S NAME (Type)
L.R. MILES, JR., M.D. | | 22d. ADDRESS
LONACONING MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/19/1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | 23d. LOCATION (City, town, or county) (State)
Lonaconing, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
GEORGE EICHHORN | | 25. ADDRESS
LONACONING, MD. | |
| 25a. MAY BE REGISTERED
MAY 19 1960 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Evans | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

1933

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5262

05272

| | | | | | | | |
|---|---|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
7 DAYS | | | |
| d. NAME OF HOSPITAL (If in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First EPHRIAM Middle STAFFORD Last STAFFORD | | | | 4. DATE OF DEATH
Month MAY Day 25 Year 1960 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV. 25, 1889 | | 9. AGE (In years last birthday)
70 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE STAFFORD | | | | 14. MOTHER'S MAIDEN NAME
MARTHA BUCY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
216-04-3011 | | 17. INFORMANT
MEMORIAL HOSPITAL CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO (c) Generalized Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 mins |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
ALGONQUIN HOTEL, CUMBERLAND, MD. | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 19 19 60 , to May 25 19 60 , that (I) (we) last saw the deceased alive on May 25 19 60 , and that death occurred at 9:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
DR. GEORGE SIMONS | | | | 22b. DATE SIGNED
5/27/60 | | 22c. PHYSICIAN'S NAME (Type)
DR. GEORGE SIMONS | |
| 22d. ADDRESS
ALGONQUIN HOTEL, CUMBERLAND, MD. | | | | 22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22f. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 28, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Herman Cemetery | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hinkle | |

100-300000

CERTIFICATE OF DEATH

100-300000

ALLIANCE

MARYLAND

ALLIANCE

(RURAL) CHARTERED

7 DAYS

RECEIVED

ROUTE 2, WILLIAM'S ROAD

RECEIVED HOSPITAL

STAFFORD

STAFFORD

WV. 2, 1928

WHITE

MALE

U.S.A.

WEST VIRGINIA

MINING

GEORGE STAFFORD

CURRENTLY, MARYLAND

HOSPITAL

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UP, GEORGE STAFFORD

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5263

CERTIFICATE OF DEATH

05273

| | | | |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 12/2/58 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. STREET ADDRESS 206 Park Street | |
| 3. NAME OF DECEASED (Type or print) First Orpha Middle B. Last Tabler | | 4. DATE OF DEATH Month May Day 31 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/10/1882 |
| 9. AGE (In years lost birthday) 77 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Christian Engle | | 14. MOTHER'S MAIDEN NAME Emma Boucher | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT P.O.Box 599 | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Hypostasis
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis
DUE TO (c) Osteo-arthritis | | INTERVAL BETWEEN ONSET AND DEATH 72 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis, & psychosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/2/58 19 to 5/31/60 19, that (I) (we) last saw the deceased alive on 5/31/60 19, and that death occurred at 7:35 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James E. McLean | | 22b. DATE SIGNED 6/1/60 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean | | 22d. ADDRESS 49 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 6/3/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum | | 23d. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 25a. REC'D BY REGISTRAR JUN 3 '60 | |
| | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



2563

CERTIFICATE OF DEATH

1937

Allegany

Marjorie

Allegany

Hammerland

12/2/38

Hammerland

Allegany County Infirmary

306 Park Street

Opera

B.

Tablet

May

11/10/1938

White

Female

Houserville

Tennoville

Christian Eagle

Emma Hammer

Allegany County Infirmary Records

12/2/38

1/3/39

Dr. James A. Nelson

Dr. Greene & Co., Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

5264

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05274

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | | | c. LENGTH OF STAY IN 1b
23 DAYS | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X CRESAPTOWN, MARYLAND | | | | d. STREET ADDRESS
KNOBLEY VIEW | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First HOY Middle (Roy) Last THOMPSON | | | | 4. DATE OF DEATH
Month MAY Day 9 Year 1960 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 13., 1892 | |
| 9. AGE (In years lost birthday)
67 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Kelly-Springfield | | | |
| 11. BIRTHPLACE (State or foreign country)
RIVERTON, W. VA. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
WEST THOMPSON | | | | 14. MOTHER'S MAIDEN NAME
Susan Clayton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
yes WWI | | | | 16. SOCIAL SECURITY NO.
214-16-2584 | | | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks
3 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 48 to 5/9 19 60 , that (I) (we) last saw the deceased alive on 5/9 19 60 , and that death occurred at 3:25 P.M. The causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dr. Weisman | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. WEISMAN | | | | 22d. ADDRESS
59 GREENE ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
May 12, 1960 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAY 16 '60 | | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanes | | | | | | | |

QUESTS

CERTIFICATE OF DEATH

DATE



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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5265
CERTIFICATE OF DEATH
05275

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|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
9/18/58 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | | | d. STREET ADDRESS
35610 Virginia Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First John Middle Henry Last Twigg | | | | 4. DATE OF DEATH
Month May Day 25 , Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/16/1880 | |
| 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired; Tin Mill Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
U. S. A. | |
| 13. FATHER'S NAME
Israel Twigg | | | | 14. MOTHER'S MAIDEN NAME (Maiden Name)
Nancy N. Twigg was Twigg | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT P.O.Box 599 Address Cumberland, Md.
Allegany County Infirmary Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
260X IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration
DUE TO Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus
(c) Chronic Nephritis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Nephritis
INTERVAL BETWEEN ONSET AND DEATH
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| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/18/58 19 to 5/25/60 19, that (I) (we) last saw the deceased alive on 5/24/60 19, and that death occurred at 10:35 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
James E. McLean | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5/25/60 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. James E. McLean | | | | 22d. ADDRESS
49 Greene Street
Cumberland, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 28, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Butial Park | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Haas | |

2265

CERTIFICATE OF DEATH

Allegany

Maryland

Allegany

June 1950

9/18/50

Allegany County, West Virginia

Allegany County, West Virginia

John

Henry

Twice

May

50

Male

White

10/16/1880

72

Residence: 1st Mill Worker

Maryland

U. S. A.

Twice

Twice

Twice

P.O. Box 100

Allegany County, West Virginia

Dr. James A. Nelson

Dr. James A. Nelson

2/25/50

9/17/50

2/25/50

10:35 A.M.

2/25/50

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

5266

05276

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|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | | | c. LENGTH OF STAY IN 1b
X La Vale, | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Disp. D.O.A. | | | | d. STREET ADDRESS
1064 Cedar St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Maude Irene Twigg | | | | 4. DATE OF DEATH
Month Day Year
5/6 -60 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 3, 1889 | |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Elk Garden, W. Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Edward Bailey | | | | 14. MOTHER'S MAIDEN NAME
Jeannette Cook | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Glenn Twigg, LaVale, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident (embolus) rt. side
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Auricular fibrillation
DUE TO
coronary arteriosclerosis
(c) Myocardial fibrosis, lt. ventricular hypertrophy | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden
1 yr. plus
? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (the hospital) attended the deceased from 12/ 19 58 to May 6 19 60 that (I) (we) last saw the deceased alive on May 2 19 60 , and that death occurred at 10:15 P from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dr. S.M. Jacobson | | | | 22b. DATE SIGNED
5/9/60 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. S.M. Jacobson | | | | 22d. ADDRESS
50 Pershing St. Cumberland, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 9, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 10 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

526 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05277

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b
<u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>1500 Virginia Avenue</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>RICHARD MALIN TWIGG</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>May 20 19 60</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 6, 1892</u> | |
| 9. AGE (In years last birthday)
<u>68</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Brkmm</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>B & O Railroad</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Orleans Crossroads, W.Va.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>Harmon Twigg</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mollie Hudson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>705-07-9505</u> | | 17. INFORMANT
Address <u>1500 Va. Ave. Cumberland, Maryland</u>
<u>Mrs. Sarah L. Twigg</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Due to Coronary Sclerosis</u>
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>May 21, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 24, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 24 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05278**

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | c. LENGTH OF STAY IN 1b
13 hours | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
512 PINE AVENUE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
GERALDINE L. VALENTINE | | | | 4. DATE OF DEATH
Month Day Year
MAY 29 19 60 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
OCTOBER 27 1941 | |
| | | | | 9. AGE (In years last birthday)
18 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
OWN HOME HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country)
Bath, New York | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
CARL STINSON | | | | 14. MOTHER'S MAIDEN NAME
ISABEL HAYES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Frank R. Valentine, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
DUE TO
672 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CONGENITAL VASCULAR ANOMALY
DUE TO
(c) --- | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3-5 Hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
(DIED 20 MINUTES POSTPARTUM) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MAY 29, 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 1, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
JUN 3 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5269

CERTIFICATE OF DEATH

05279

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
02 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
D. O. A. Memorial Hospital | | | | d. STREET ADDRESS
28 Schiller Terrace | | | |
| 3. NAME OF DECEASED (Type or print)
First Harley Middle C. Last Wagoner | | | | 4. DATE OF DEATH
Month May Day 22 Year 1960 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 10, 1880 | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer (Retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Celanese Corp. of America | | 11. BIRTHPLACE (State or foreign country)
Keyser, W. Va. | |
| 13. FATHER'S NAME
Charles Wagoner | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
214-07-1929 | | 17. INFORMANT
Sadie L. Wagoner Address 28 Shiller Terrace, Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiovascular
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart disease (Arteriosclerosis)
DUE TO (c) 10 yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 5-10-60 , 19 60 , to May 22 , 19 60 , that I last saw the deceased alive on 5-15-1960 , and that death occurred at 6 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 122 S. Centre Street DATE SIGNED 5/24/60
ACTUAL SIGNATURE Wm. F. Williams M.D.
PHYSICIAN'S NAME (Type) Richard J. Williams, M.D. Cumberland, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/25/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc. | | | | ADDRESS
117 Frederick St. Cumb. Md. | | 24a. REC'D BY REGISTRAR
DATE MAY 26 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Richard S. Kraus | | | |

CERTIFICATE OF DEATH

05280

Reg. Dist. No.

5270

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>829 Buckingham Rd.</u> | | d. STREET ADDRESS <u>829 Buckingham Rd</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>H.</u> Last <u>Walker</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 30, 1893</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. & Treasurer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield Fire Co</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Walker</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Chalfont</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u> | | 16. SOCIAL SECURITY NO. <u>261-01-0849</u> | |
| 17. INFORMANT <u>Mrs. Wm. H. Walker</u> | | Address <u>Cumb. Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Testis</u>
DUE TO <u>154X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Carcinoma of scrotum</u>
DUE TO
(c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 months</u>
<u>4 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 5, 1956</u> , to <u>May 24, 1960</u> , that I last saw the deceased alive on <u>May 21, 1960</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) <u>133 S. Centre St. Cumberland Md</u> | |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | DATE SIGNED <u>5-26-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>5/28/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Beinhauer Crematory</u> | 22d. LOCATION (City, town, or county) (State) <u>Pittsburg Pa</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u> | | ADDRESS <u>Cumb. Md</u> | |
| 24a. REC'D BY REGISTRAR <u>[Signature]</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |
| DATE <u>MAY 31 '60</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2892

1891

Blank form with horizontal lines for text entry.

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05282
Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|-------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE West Virginia b. COUNTY Mineral | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ridgeley | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SACRED HEART HOSPITAL | | | | d. STREET ADDRESS
117 Main St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Elijah Middle Thomas Last Wheeler | | | | 4. DATE OF DEATH
Month May Day 26 Year 19 60 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 18, 1882 | | 9. AGE (In years last birthday)
78 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY
Kelly-Tire Co. | | 11. BIRTHPLACE (State or foreign country)
Jones Spring, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
William Wheeler | | | | 14. MOTHER'S MAIDEN NAME
Sarah C. Everhart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
214-07-0647 | | 17. INFORMANT
Address Ridgeley, W. Va.
Mrs. Pauline Wilkinson Carpenters' Add. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
420-1 DUE TO CORONARY SCLEROSIS
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2-3 Hrs.
---- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | MAY 26, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/28/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
DATE MAY 31 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH, AND BY THE REGISTRAR OF DEATHS, WHO SHALL SIGN AND FILE IT IN THE OFFICE OF THE BUREAU OF VITAL STATISTICS, AND WHO SHALL RETURN A COPY OF IT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DEATH OCCURRED.

NAME OF DECEASED: JOHN J. HARRIS

AGE: 45 YEARS

SEX: MALE

RACE: WHITE

DATE OF BIRTH: 1875

PLACE OF BIRTH: TEXAS

EDUCATION: GRADUATE

OCCUPATION: DRUGGIST

RELIGION: METHODIST

DATE OF DEATH: 1925

PLACE OF DEATH: HOUSTON, TEXAS

CAUSE OF DEATH: HEART DISEASE

IMMEDIATE CAUSE: HEART DISEASE

PREVIOUS CAUSE: HEART DISEASE

PERIOD OF ILLNESS: ONE WEEK

DATE OF ONSET: 1925

DATE OF RECOVERY: 1925

DATE OF DEATH: 1925

PLACE OF DEATH: HOUSTON, TEXAS

CAUSE OF DEATH: HEART DISEASE

IMMEDIATE CAUSE: HEART DISEASE

PREVIOUS CAUSE: HEART DISEASE

PERIOD OF ILLNESS: ONE WEEK

DATE OF ONSET: 1925

DATE OF RECOVERY: 1925

DATE OF DEATH: 1925

PLACE OF DEATH: HOUSTON, TEXAS

CAUSE OF DEATH: HEART DISEASE

IMMEDIATE CAUSE: HEART DISEASE

PREVIOUS CAUSE: HEART DISEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5287 CERTIFICATE OF DEATH

05283

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
22 FROSTBURG | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
89 BRADDOCK ROAD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle F. Last WHETSTONE | | 4. DATE OF DEATH
Month MAY Day 30 Year 19 60 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 17, 1889 |
| 9. AGE (In years lost birthday) yrs.
70 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MOLDER | | 10b. KIND OF BUSINESS OR INDUSTRY
BIG SAVAGE REFRACTORIES | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOSEPH WHETSTONE | | 14. MOTHER'S MAIDEN NAME
CATHERINE HOUSE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-10-9876 | |
| 17. INFORMANT
MRS. JAS. WHETSTONE, | | Address
89 BRADDOCK RD., FROSTBURG, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure - Rt Side
DUE TO arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease
DUE TO (c) years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days
INTERVAL BETWEEN ONSET AND DEATH years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1949 to May 30 1960 that (I) (we) last saw the deceased alive on May 30 1960 and that death occurred at 2 P. M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John B. Davis, | | 22b. DATE
6/1/60 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN B. DAVIS, M. D. | | 22d. ADDRESS
Frostburg Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
6-2-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | | 23d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. R. Burt | | 25a. REC'D BY REGISTRAR
DATE JUN 2 '60 | |
| ADDRESS
FROSTBURG, MD. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

5287

CERTIFICATE OF DEATH

0321

1

1. NAME (Last, first, middle initial)
2. DATE OF BIRTH (Month, day, year)
3. PLACE OF BIRTH (City, State, Country)
4. SEX (Male, Female)
5. RACE (White, Negro, American Indian, Alaska Native, Hawaiian, Other)
6. OCCUPATION (If any)
7. MARITAL STATUS (Single, Married, Widowed, Divorced)
8. DATE OF DEATH (Month, day, year)
9. PLACE OF DEATH (City, State, Country)
10. CAUSE OF DEATH (If known)
11. SIGNATURE OF DECEASED (If living)
12. SIGNATURE OF WITNESS (If any)
13. SIGNATURE OF DECEASED'S NEXT OF KIN (If any)
14. SIGNATURE OF PHYSICIAN (If any)
15. SIGNATURE OF MINISTER OF RELIGION (If any)
16. SIGNATURE OF CHAPLAIN (If any)
17. SIGNATURE OF CLERGYMAN (If any)
18. SIGNATURE OF OTHER (If any)
19. SIGNATURE OF DECEASED'S NEXT OF KIN (If any)
20. SIGNATURE OF PHYSICIAN (If any)
21. SIGNATURE OF MINISTER OF RELIGION (If any)
22. SIGNATURE OF CHAPLAIN (If any)
23. SIGNATURE OF CLERGYMAN (If any)
24. SIGNATURE OF OTHER (If any)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5272

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05284

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY HARDY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
3 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MOOREFIELD 85X-3 |
| d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
WARWICK & MEMORIAL AVENUES | | d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ELEANOR Middle P. Last WILLIAMS | | 4. DATE OF DEATH
Month MAY Day 6 Year 19 60. | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 21, |
| 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
EDWARD WILLIAMS | | 14. MOTHER'S MAIDEN NAME
ANNIE E. VAN METER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonitis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Perf. Cecum
DUE TO
(c) Hodgkin's Disease
INTERVAL BETWEEN ONSET AND DEATH
7-10d.
7-10d.
1 yr. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-12-60 to 5-12-60 , 19 60 , that (I) (we) last saw the deceased alive on 5-12 1960, and that death occurred at 8:00 P.M. on the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. A. J. Mirkkin | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. A. J. MIRKIN | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 9, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
OLIVET | | 23d. LOCATION (City, town, or county) (State)
MOOREFIELD, W. VA. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
KEITH SHAFFER - | | 25a. REC'D BY REGISTRAR
DATE MAY 24 '60 | |
| ADDRESS
ROMNEY, W. VA. | | 25b. REGISTRAR'S SIGNATURE
Charles S. Kneass | |

(M)
060

1

03834

CERTIFICATE OF DEATH

5873



WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

ROCKWELL

2 DAYS

ROCKWELL

ROCKWELL HOSPITAL

ROCKWELL HOSPITAL

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

U.S.A.

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

25

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

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WEST VIRGINIA

WEST VIRGINIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5273

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05285

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY GARRETT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
5 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | d. STREET ADDRESS
RT. #3, BOX 169 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNIE Middle G. Last WILT | | | | 4. DATE OF DEATH
Month MAY Day 17 Year 19 60 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DECEMBER 10 | |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months 65 Days 65 Hours 65 Min. | | IF UNDER 24 HRS.
Months 65 Days 65 Hours 65 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House work | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
GARRETT, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Max Layman | | | | 14. MOTHER'S MAIDEN NAME
LAURA C. WILHELM | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular-renal disease
442X DUE TO (b) disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) disease | | | | INTERVAL BETWEEN ONSET AND DEATH
5 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Frostburg | | | | 20g. (County)
Frostburg | | 20h. (State)
Md. | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-13 19 60 to 5-17 19 60 that (I) (we) lost saw the deceased alive on 5-17 19 60 and that death occurred 4:35 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ralph L. Ballin | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-18-60 | |
| 22c. PHYSICIAN'S NAME (Type)
RALPH BALLIN | | | | 22d. ADDRESS
62 GREENE ST., CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 20 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Frostburg Mem. Pk. | | 23d. LOCATION (City, town, or county) (State)
Frostburg Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Beulah H. Montezant | | | | 25a. REC'D BY REGISTRAR
DATE MAY 23 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kneass | |



8333

CERTIFICATE OF DEATH

01588

ALLICORN

WINDLAND

GARRETT

CURRIANO

FRONTING

5 DAYS

MEMORIAL HOSPITAL
MEMORIAL & MEDICAL BLDG.

ST. 42, BOX 180

ANNE

WILL

MAY

DECEMBER 10

WHITE

FEMALE

GARRETT, NO.

U.S.A.

LAURA C. WILHELM

MEMORIAL HOSPITAL, GARRETT, NO.

MEMORIAL HOSPITAL - 1001

U.S.A.



BACON BATH

ST. 42, BOX 180

MAY 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5274

05286

| | | | | |
|--|----------------------------------|---|------------------------------------|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
7 DAYS | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
EFFIE | | 4. DATE OF DEATH
Month MAY Day 19 Year 1960 | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 20 | |
| 9. AGE (In years last birthday)
71 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| 11. BIRTHPLACE (State or foreign country)
GARRETT CO., MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
THOMAS WILT | | 14. MOTHER'S MAIDEN NAME
ELIZABETH PLATTER | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
MEMORIAL HOSPITAL CUMBERLAND, MD. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident - hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypertension
DUE TO
(c) Uremia | | | | INTERVAL BETWEEN ONSET AND DEATH
10 days

?? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/12 1960 to 5/19/60 , that (I) (we) last saw the deceased alive on 5/19 19 60 , and that death occurred at 1:15 PM from the causes and on the date stated above. | | | | |
| 22a. SIGNATURE
<i>Samuel Jacobson</i> | | 22b. DATE
5/20/60 | | |
| 22c. PHYSICIAN'S NAME (Type)
DR. SAMUEL JACOBSON | | 22d. ADDRESS
50 PERSHING ST., CUMBERLAND, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/22/60 | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Philos | | 23d. LOCATION (City, town, or county) (State)
Westernport Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Ed. Boral</i> | | ADDRESS
Westernport, Md. | | |
| 25a. REC'D BY REGISTRAR
DATE MAY 25 '60 | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | | |

(M)

(1)

ALABAMA

CUMBERLAND

7 DAYS

W. STEINBOCK

ALL DAY

RECEIVED 10/10/50

201 W. 10th St.

1950

1950

1950

WHITE

WHITE

WHITE

THOMAS WILK

10 COLUMBIA STREET

MEMORIAL HOSPITAL CUMBERLAND, MD.

James Memorial Hospital - Cumberland

Investigation

1950

DR. SAMUEL L. GIBSON

10 PENSING ST., CUMBERLAND, MD.